Supreme Court, U.S.
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IN THE

# Supreme Court of the United States

VYTRA HEALTHCARE AND BRENT SPEARS, M.D.,

*Petitioners,*

v.

BONNIE CICIO,

*Respondent.*

**On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit**

## PETITION FOR A WRIT OF CERTIORARI

CHARLES G. MOERDLER
STROOCK & STROOCK
& LAVAN LLP
180 Maiden Lane
New York, NY 10038
(212) 806-5400

*Of Counsel*

GLEN D. NAGER
(*Counsel of Record*)
TRACI L. LOVITT
JONES DAY
51 Louisiana Ave., N.W.
Washington, D.C. 20001
(202) 879-3939

*Counsel for Petitioners*

119 pp

## QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, preempts state law claims that challenge a non-treating physician's alleged medical judgment in determining eligibility for coverage under an employee benefit plan?

## PARTIES TO THE PROCEEDING

Petitioners are (1) Vytra Health Plans Long Island, Inc., a not-for-profit independent practice association model Health Maintenance Organization, which is controlled by and affiliated with Health Insurance Plan of Greater New York, Inc., a New York not-for-profit corporation, and (2) Brent Spears, M.D., who at all applicable times was the medical director of Vytra Health Plans. Respondent is Bonnie Cicio, acting individually and as administratrix of the estate of Carmine Cicio.

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## OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-44a) is reported at 321 F.3d 83, and the district court's opinion (Pet. App. 45a-52a) is reported at 208 F. Supp. 2d 288.

## JURISDICTION

The district court exercised jurisdiction over the plaintiff's claims under 28 U.S.C. § 1331, the complete preemption brought about by 29 U.S.C. § 1132, and the supplemental jurisdiction provision, 28 U.S.C. § 1367(a). The court of appeals asserted jurisdiction pursuant to 28 U.S.C. § 1291, and entered judgment on February 11, 2003. The court of appeals subsequently denied a timely-filed petition for rehearing and for rehearing *en banc* on April 21, 2003. Pet. App. 71a-72a. Jurisdiction in this Court exists under 28 U.S.C. § 1254(1).

## CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution, U.S. Const. art. VI, cl. 2, provides in pertinent part:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the contrary notwithstanding.

Section 502(a) of ERISA, 29 U.S.C. § 1132(a) states in pertinent part:

> (a) Persons empowered to bring a civil action. A civil action may be brought (1) by a participant or beneficiary (A) for the relief provided in sub-section (c) of this section, or (B) to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . . .

Section 514(a) of ERISA, 29 U.S.C. § 1144(a), states as follows:

> (a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

## STATEMENT

This case squarely presents a recurring federal question that is dividing and confusing the lower courts—namely, whether ERISA preempts state law claims that challenge a medical judgment made in connection with a benefit eligibility determination by a non-treating physician. This important question deserves this Court's immediate attention.

1. In 1974, after a decade of study, Congress enacted ERISA, a declared policy of which is to protect participants in employee benefit plans "by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b), (c). ERISA generally leaves to plan sponsors the decision whether to establish a benefit plan and, if so, the substantive terms of such a plan. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 512-13 (1981). But once an employer decides to establish a plan, ERISA imposes requirements for reporting and disclosure relating to such plans. 29 U.S.C. §§ 1021-1031. It also establishes certain standards of conduct for fiduciaries of employee benefit plans. *Id.* §§ 1101-1114. And it establishes comprehensive rules for the administration and enforcement of employee rights in such plans. *Id.* §§ 1131-1145.

As part of this scheme, § 502(a) of ERISA authorizes a participant, beneficiary, or fiduciary to bring suit "to recover benefits due to him under the terms of his plan, to enforce his

rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan" or generally "to enjoin any act or practice which violates any provision of [Title I of ERISA] or the terms of the plan." 29 U.S.C. §§ 1132(a)(1)(B), (3). Section 502 also confers exclusive federal jurisdiction over such suits. 29 U.S.C. § 1132(e)(1).

ERISA further provides in § 514(a) that, except where expressly noted otherwise, "the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any [covered] employee benefit plan . . . ." 29 U.S.C. § 1144(a). The principal goal of § 514(a) is "to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987).

In light of ERISA's uniformity goal, this Court has recognized that state laws can be preempted by ERISA in at least two ways. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138-44 (1990) (discussing ERISA's preemptive scope). *First*, § 502(a) completely preempts state law causes of action that add to or alter the remedies created under that section. *See id.* at 144-45; *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 377-81 (2002). *Second*, under § 514(a) of ERISA, state laws that "refer to" or have a "connection with" an employee benefit plan are also preempted. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987).

2. Petitioner Vytra Health Plans Long Island, Inc. ("Vytra"), is a Health Maintenance Organization ("HMO") that administers healthcare benefits to subscribers. Vytra contracts with employers to provide these benefits under an "Agreement for Comprehensive Health Services" (the "Plan"), an "employee benefit plan" within the meaning of ERISA, *see* 29 U.S.C. § 1002(3). Pet. App. 3a.

Respondent Bonnie Cicio ("Cicio") and her late husband Carmine Cicio received benefits under the Plan through Cicio's employer, North Fork Bank. As part of the Plan, the Cicios were entitled to "diagnosis and treatment of disease, injury or other conditions." *Id.* (quoting Plan Art. III, § 3.1(b)).

Vytra was not, however, required under the Plan to provide medical services unless they were medically "necessary." *Id.*; *see also id.* at 78a (Plan Art. III, § 3.5(a)) ("Vytra shall provide only Medically Necessary Vytra Services."). Vytra also was not required to provide "'[a]ny procedure or service which, in the judgment of Vytra's Medical Director, is experimental or is not generally recognized to be effective for a particular condition, diagnosis, or body area.'" *Id.* at 4a (quoting Plan Art. IX, § 9.3(f)).

In March 1997, Mr. Cicio was diagnosed with multiple myeloma, a form of blood cancer. Pet. App. 2a. After one type of chemotherapy failed, Mr. Cicio's then-treating oncologist, Dr. Edward Samuel, wrote Vytra "request[ing] insurance approval for treatment of Mr. Cicio with high dose chemotherapy supported with peripheral blood stem cell transplantation, in a tandem double transplant, for a diagnosis of multiple myeloma." *Id.* at 4a (citing Letter from Edward T. Samuel to Vytra dated January 28, 1998, at 1). Vytra's medical director, Dr. Brent Spears, denied Dr. Samuel's request. *Id.* Dr. Spears explained that the proposed procedure was "not a covered benefit according to this member's plan which states [that] experimental/investigational procedures are not covered." *Id.* (citing Letter from Brent W. Spears to Edward T. Samuel dated February 23, 1998, at 1).

Dr. Samuel wrote again to Dr. Spears, arguing that double or single stem transplants are promising treatments for multiple myeloma. Pet. App. 5a. Dr. Spears responded that a single stem cell transplant for Mr. Cicio would be covered by the Plan, but again denied coverage for a tandem stem cell

transplant. *Id.* (citing Letter from Brent W. Spears to Edward T. Samuel dated March 25, 1998, at 1). According to the Complaint, Mr. Cicio was, by that time, no longer a candidate for a double stem cell transplant and died on May 11, 1998. *Id.* (citing Compl. ¶ 31).

3. Respondent Cicio subsequently filed a complaint, on behalf of herself and the estate of her late husband in the New York State Supreme Court. Pet. App. 6a. The Complaint alleges eighteen state law causes of action based on Dr. Spears' conclusion that tandem stem cell transplants are experimental and thus not covered under the Plan. *Id.*

On May 30, 2000, Vytra and Dr. Spears (hereinafter, collectively "Vytra") removed the proceedings to the United States District Court for the Eastern District of New York. *Id.* On June 21, 2000, Vytra moved to dismiss the complaint for failure to state a claim. *Id.*

The motion was referred to Magistrate Judge E. Thomas Boyle, who found that the court had removal jurisdiction and that Vytra's Rule 12(b)(6) motion should be granted. Pet. App. 53a-70a. In relevant part, Judge Boyle reasoned that Cicio's state law claims were preempted under §§ 502(a) and 514(a) of ERISA, 29 U.S.C. §§ 1132(a)(1)(B), 1144(a), because "Vytra functioned solely as a plan administrator and bore no responsibility as a provider of medical services . . . . For this reason, the challenge here does not target the quality of care but rather attacks the benefits decision that was made." Pet. App. 67a.

The district court adopted the report and recommendation in full. *Id.* at 45a-52a. The court agreed that the Plan was an "employee benefit plan" under ERISA and thus subject to its requirements. *Id.* at 48a. In addition, the court agreed that Cicio's claims could not escape preemption simply because they arose from an eligibility determination involving medical judgment. *Id.* at 50a-51a.

4. In a divided decision, the Second Circuit reversed in part. Pet. App. 1a-44a. While the court affirmed the dismissal of most of Cicio's claims, it held that Cicio's medical malpractice claims were not preempted. *Id.* at 31a-36a.

a. With respect to the malpractice claims, the court found that such claims were different from the other claims asserted in Cicio's Complaint, because they involved Vytra's exercise of medical judgment, namely its decision that the treatment proposed by Dr. Samuel was experimental. *Id.* at 30a-31a. According to the Second Circuit, ERISA does not preempt such a traditional area of state law, even where mere coverage determinations are at issue. *Id.* at 31a-33a.

The Second Circuit based its holding on *Pegram v. Herdrich*, 530 U.S. 211 (2000). Although the Second Circuit recognized that *Pegram* was not an ERISA preemption case but concerned "only whether an HMO had . . . breached its fiduciary duty to members" (Pet. App. 28a), the court concluded that *Pegram* was nonetheless determinative:

> [*Pegram*] suggests that . . . some [healthcare] decisions involve interpretation of a benefits contract, eligibility decisions, and some involve application of medical judgment to a particular patient's condition, treatment decisions. And these two categories overlap. The resulting third category, described in *Pegram*, of "mixed eligibility and treatment decisions," is not limited to decisions made by treating physicians . . . who both assess which benefits a plan provides and make treatment decisions . . . . [E]ven if a physician does not directly control, direct, or influence a plaintiff's treatment, and even if the sole consequence of a physician's decision is reimbursement or its denial, that decision may nonetheless be a mixed eligibility and treatment decision.

*Id.* at 29a-30a (internal citations omitted).

In light of *Pegram*, the Second Circuit found that a "categorical distinction between 'quality of care' decisions and 'benefits administration' questions . . . . is no longer tenable." *Id.* at 31a-32a. Rather, *Pegram* "strongly suggests" that mixed eligibility determinations are not preempted and "that a defendant can no longer simply point to the overlay of medical decision-making on contractual claims and ask the Court to conclude that, because ERISA preempts the contract claims, it also preempts all state tort-law claims based on the same decision." *Id.* at 32a. Based on *Pegram*, the court held that Dr. Spears' denial "must be treated as a mixed decision because it allegedly involved both an exercise of medical judgment and an element of contract interpretation," and thus claims based on his decision were not preempted. *Id.* at 31a.

The Second Circuit recognized that "[o]ther courts addressing similar facts have concluded that malpractice claims based on utilization review decisions are indeed preempted by § 514." Pet. App. 26a (citing *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1326 (5th Cir. 1992), *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488 (7th Cir. 1996), and *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995)). In the Second Circuit's view, these decisions were no longer persuasive because they "were decided before the Supreme Court's recent retrenchment of ERISA's preemption's margins, and before the Court, in its unanimous decision in *Pegram v. Herdrich*, addressed (albeit in *dicta*) medical malpractice actions against those engaged in medical decision making." *Id.* at 27a. The Second Circuit also recognized that its decision conflicted with the post-*Pegram* decision in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 273 (3d Cir. 2001). Pet. App. 31a. But the court "decline[d] to adopt the categorical distinction between 'quality of care' decisions and 'benefits administration' questions applied by" the Third Circuit in that case. *Id.* In the Second Circuit's view, "*Pegram* teaches that this dichotomy is no longer tenable." *Id.* at 32a.

b. Judge Calabresi dissented. Pet. App. 37a-44a. In his view, "the majority's holding [could not be reconciled] with the Supreme Court's precedents and with the structure of ERISA itself, given those precedents." *Id.* at 38a. He reasoned:

> On these facts it seems to me clear beyond peradventure a) that the plan administrators were not, in any way, acting as Mr. Cicio's doctors, b) that what they were doing was—perhaps negligently—determining the scope and coverage of an ERISA-plan contract, c) that as a result of that allegedly improper denial of coverage, Mr. Cicio was financially unable to obtain, in time, the treatment he and his treating physician continued to seek, and d) that catastrophic, consequential damages—Mr. Cicio's death—flowed from the improper misreading of the ERISA-plan coverage. Mrs. Cicio then sued for those damages. If this is not a paradigmatic suit to remedy the violation of rights under the terms of the plan, I don't know what is.

*Id.* at 42a-43a. Judge Calabresi added that the majority made too "much of the fact that the coverage decision was erroneously made because of a *medical error* on the plan administrator's part. That may well be, but that fact seems to me irrelevant." *Id.* at 43a (emphasis in original).

With respect to *Pegram*, Judge Calabresi argued that the Court's *dicta* about preemption could "only make sense where the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such a physician's employer, as was the case in *Pegram*." *Id.* at 43a-44a. But "[w]here, as here, no such relationship exist[s], there is no apparent reason, in state or federal law, for treating the unlawful coverage decision any differently from any other unlawful coverage decision that is *not* based on medical error." *Id.* at 44a (emphasis in original).

5. On April 21, 2003, the Second Circuit denied a timely-filed petition for rehearing and rehearing *en banc*. Pet. App. 71a-72a.

## REASONS FOR GRANTING THE WRIT

Every day, administrators of employee benefit plans, including non-treating physicians, make judgments about whether a proposed treatment is eligible for coverage under a benefit plan. Many of these judgments involve medical or clinical considerations, as benefit plans usually cover, for example, only "medically necessary" procedures and frequently exclude "experimental" treatments.

In *Pegram*, this Court considered whether medically-based coverage determinations, when made by a treating physician, are fiduciary acts under ERISA and held that such "mixed eligibility" decisions are not fiduciary acts. In doing so, the Court noted in *dicta* that its holding avoided "a puzzling issue of preemption"—to wit, whether applying federal fiduciary law to "mixed eligibility" decisions would preempt state medical malpractice challenges. *Pegram*, 530 U.S. at 236.

Since *Pegram* was decided, both the Executive Branch and numerous circuit courts and state courts of last resort have struggled to resolve a distinct but related preemption question under ERISA—namely, whether ERISA preempts state law claims challenging a non-treating physician's alleged medical judgment in determining eligibility for coverage under an employee benefit plan. The Executive Branch has argued to this Court that such state law causes of action should be preempted. But the lower courts have split into at least four different camps on the issue, and the jurisprudence in this area has become hopelessly confused. Seizing upon the *dicta* in *Pegram*, the Second Circuit and one state court of last resort have held that ERISA does not preempt state law claims challenging a non-treating physician's alleged medical judgment made in determining eligibility for coverage. In contrast, four other federal circuit courts—the Third, Fourth,

Sixth, and Eighth—have held these causes of action preempted under §§ 502(a) and 514(a) of ERISA. The Fifth Circuit has held that alleged medically-based eligibility determinations do not fall within the scope of § 502(a) of ERISA but are preempted under § 514(a). Finally, the Maryland Court of Appeals has held that ERISA preempts state law claims that challenge eligibility decisions unless a traditional medical malpractice action is involved.

This Court should clarify this confusion. The preemption issue dividing the courts is of vital importance. In addition, allowing the confusion to remain is contrary to ERISA's own expressed interest in uniform national rules for benefit plans. Finally, as Judge Calabresi argued in dissent below, the Second Circuit's view of this ERISA preemption question cannot be squared with this "Court's precedents and with the structure of ERISA itself . . . ." Pet. App. 38a.

## I. THE DECISION BELOW ADDS TO THE CONSIDERABLE CONFUSION IN THE LOWER COURTS ABOUT WHETHER, AFTER *PEGRAM*, ERISA PREEMPTS STATE LAW CLAIMS INVOLVING ALLEGED MEDICALLY-BASED ELIGIBILITY DETERMINATIONS.

Prior to *Pegram*, at least seven federal courts of appeal—the First, Fifth, Sixth, Seventh, Eighth, Ninth, and Tenth Circuits—had concluded that state law claims challenging alleged medically-based eligibility determinations are preempted by ERISA. *See Turner v. Fallon Community Health Plan, Inc.*, 127 F.3d 196, 199-200 (1st Cir. 1997) (denial of breast cancer treatment on ground that it was experimental was not actionable in light of ERISA preemption); *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1, 5-7 (1st Cir. 1999) ("Although we recognize that the allegedly negligent decision making and consultation at issue here may be characterized as medical in nature, this fact alone does not remove the state causes of action from the scope of

§ 502(a)."); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992) (state law claims based on denial of hospitalization benefits as medically unnecessary not actionable because a benefit plan administrator "makes medical decisions as part and parcel of its mandate to decide what benefits are available."); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 942-43 (6th Cir. 1995) (claims based on denial of hospitalization as medically unnecessary preempted by ERISA); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1493 (7th Cir. 1996) (alleged failure to treat preempted as related to eligibility decision); *Thompson v. Gencare Health Sys., Inc.*, 202 F.3d 1072, 1073-74 (8th Cir. 2000) (refusal to extend benefits for breast cancer treatment as medically unnecessary was not actionable under medical malpractice law); *Kuhl v. Lincoln Nat'l Health Plan of Kan. City, Inc.*, 999 F.2d 298 (8th Cir. 1993) (state law claims based on delay in approving heart surgery preempted); *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1008 (9th Cir. 1998) (no state law claim allowed for breast cancer treatment denied as experimental); *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270, 1273-74 (10th Cir. 1996) (decision to deny leukemia treatment as experimental could not be the basis of state law claims because claims were preempted by ERISA). Three circuits had, indeed, rejected state law claims based on the exact factual scenario here—specifically, an allegation that a non-treating physician was negligent in denying coverage for some proposed medical treatment as experimental. *Bast*, 150 F.3d at 1008; *Turner*, 127 F.3d at 199-200; *Cannon*, 77 F.3d at 1273-74.

This widespread judicial consensus quickly eroded in the wake of this Court's decision in *Pegram*. Since June 2000, at least six federal circuit courts and two state courts of last resort have considered whether state law claims challenging alleged medically-based eligibility determinations are preempted by ERISA, and they have rendered conflicting decisions based on four different, inconsistent rationales.

Some courts have held that state law claims concerning alleged medically-based eligibility determinations are not preempted at all, under any provision of ERISA. Others, however, have held that such claims are completely preempted under §§ 502(a) and 514(a) of ERISA. Still another court has held that, while state law claims are not within the scope of § 502(a), they are preempted under § 514(a). Finally, one court has held that ERISA preempts state law claims except insofar as a traditional malpractice claim is involved.

In the first camp, the Pennsylvania Supreme Court has joined the Second Circuit and held that alleged medically-based eligibility determinations are not preempted by any provision of ERISA. *See Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001), *cert. denied sub nom. U.S. Healthcare Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 536 U.S. 938 (2002). Like the Second Circuit, the Pennsylvania Supreme Court concluded that *Pegram* instructs that a "mixed eligibility and treatment decision implicates a state law claim for medical malpractice, not an ERISA cause of action for fiduciary breach. Thus if [plaintiff's] third party claim against [the benefit plan administrator] arose out of a mixed decision, it is, according to *Pegram*, subject to state medical malpractice law." *Pappas*, 768 A.2d. at 1095; *see also id.* at 1096 ("His was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed, as *Pegram* teaches, through state medical malpractice law. This law . . . is not preempted by ERISA."). *See also Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842, 850-51 (Fla. 2003) (although not deciding preemption question here, observing that *Cicio* decision "is consistent with and reflective of the current state of the law in Florida" and that it will apply in future preemption cases "the analysis employed in . . . *Pappas*.").

In contrast, the Third, Fourth and Sixth Circuits have held that state law claims challenging alleged medically-based eligibility determinations are preempted by both §§ 502(a) and

514(a) of ERISA. The Eighth Circuit has indicated that it is in this camp as well.

In *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), a post-*Pegram* decision that the Second Circuit expressly acknowledged conflicts with its own (Pet. App. 31a), the Third Circuit held that a state law claim seeking damages for a denial of coverage was completely preempted by ERISA. The court acknowledged that *Pegram* "suggests preferable terminology" for courts to use when analyzing ERISA claims, but concluded that *Pegram* ultimately does not alter preemption analysis:

> [r]egardless of the language used, the ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action.

*Id.* at 273. Accordingly, the court reaffirmed its pre-*Pegram* preemption decisions, *see id.* (citing *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 356 (3d Cir. 1995)), and held that "a claim alleging that an HMO declined to approve certain requested medical services or treatment on the ground that they were not covered under the plan would manifestly be one regarding the proper administration of benefits. Such a claim, no matter how couched, is completely preempted and removable on that basis." *Id.*

Similarly, in *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003), the Fourth Circuit held that state law claims challenging alleged medically-based eligibility determinations are completely preempted by ERISA. It, too, rejected the argument that *Pegram* should be read to alter ERISA's preemption analysis:

> [E]ven though the distinction between pure eligibility decisions and treatment decisions may tend to blur when the treating physician is also responsible for making eligibility decisions . . . that is not the case here where the treating physicians and [benefits administrator] were institutionally segregated from one another. [The administrator] worked for an independent utilization review agent that was under contract with [a preferred provider network] . . . and the treating physicians were simply employed by, or connected with, the hospital to which [the insured] was admitted. Under this arrangement, treatment decisions and eligibility decisions were made by different people at different times according to different policies."

*Id.* at 326. The Fourth Circuit concluded that the plaintiffs could not "transform what is properly considered a § 502(a) claim into a state-law claim for malpractice simply by making unsubstantiated and incorrect statements that an independent utilization review agent was responsible for medical decisions." *Id.* at 326-37.

The Sixth Circuit has also reaffirmed, since *Pegram* was decided, its earlier decisions holding state law actions arising from medically-based eligibility determinations preempted. Specifically, in *Caffey v. Unum Life Ins. Co.*, 302 F.3d 576, 582 (6th Cir. 2002), the Sixth Circuit considered a state law claim arising from a benefit administrator's decision that a proposed medical treatment was not covered, in part, because the treating physician's diagnosis was incorrect. *Id.* at 579. The court concluded that the claim was preempted because "[a]ll of plaintiff's state-law claims stem from the actions of [the administrator] in the processing of her claim for benefits." *Id.* at 582. Although the court did not specifically discuss *Pegram*, it concluded that its view of ERISA preemption was compelled by this Court's jurisprudence. *See id.*

The Eighth Circuit has also strongly indicated in a pair of cases that state law claims challenging alleged medically-

based eligibility determinations are preempted. Prior to *Pegram*, in *Thompson v. Gencare Health-Systems, Inc.*, 202 F.3d 1072, 1073 (8th Cir. 2000), the court rejected the argument that a plaintiff's medical malpractice claim was not preempted because it implicated a medical judgment, reasoning that the plaintiff "and her treating physicians retained the ultimate decision-making authority regarding her medical care." *Id.* at 1074. Subsequently, in *Howard v. Coventry Health Care of Iowa, Inc.*, 293 F.3d 442 (8th Cir. 2002), the court refused to modify its ERISA preemption analysis in light of *Pegram*:

> *Pegram* addresses an issue not before this court: ERISA actions in the context of claims for breach of duties by plan fiduciaries. Moreover, *Pegram* did not hold that all quality of care claims exist outside the scope of ERISA or support [plaintiff's] contention of a cause of action outside of ERISA. Thus, *Pegram* does not support [plaintiff's] claim.

*Id.* at 445 (internal citations omitted).

In contrast to these courts, the Fifth Circuit has concluded that state law challenges to alleged medically-based eligibility determinations are *not* preempted under § 502(a) of ERISA but are subject to § 514(a) preemption. In *Roark v. Humana, Inc.*, 307 F.3d 298, 315 (5th Cir. 2002), *petition for cert. filed*, 71 U.S.L.W. 3791 (U.S. June 3, 2003) (No. 02-1826), and *petition for cert. filed sub nom. Aetna Health Inc. v. Davila*, -- U.S.L.W. -- (U.S. June 20, 2003) (No. 02-1845), the Fifth Circuit considered four consolidated appeals, all of which involved coverage claims asserting delay or refusal of physician-recommended treatment. The court reasoned that *Pegram* altered the analysis of complete preemption under § 502(a) of ERISA such that an eligibility determination involving a medical judgment by a non-treating physician was not completely preempted by that section of ERISA. *Id.* at 307-08. In the court's view, *Pegram* suggested that § 502(a) was not intended to federalize medical malpractice law, and

claims challenging medically-based eligibility determinations are such malpractice challenges. *Id.* at 308-11. With respect to preemption under § 514 of ERISA, however, the court concluded that *Pegram* could *not* be read to overrule the Fifth Circuit's earlier decisions holding that claims involving alleged medically-based eligibility determinations are preempted by this provision of ERISA. *Id.* (citing *Corcoran*, 965 F.2d at 1332-34). An *en banc* panel of the Fifth Circuit subsequently declined to rehear the case *en banc* or revisit its earlier § 514 precedent. *See also Haynes v. Prudential Health Care*, 313 F.3d 330, 336 (5th Cir. 2002) ("[W]e do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment.").

The final approach to preemption was announced by the Maryland Court of Appeals in *Eid v. Duke*, 816 A.2d 844 (Md. 2003). Without specifying the particular source of ERISA preemption, the court held that a cause of action challenging an alleged medically-based eligibility determination is preempted unless it states a claim under traditional malpractice law. In the Maryland Court of Appeals' view, *Pegram* means that:

> [T]he issue of preemption is inextricably bound up with the availability of a traditional medical malpractice claim under state law. If the nature of the action constitutes a traditional state law medical malpractice action, it is probably not preempted by ERISA. If, however, a physician's decision would not give rise to a traditional medical malpractice action, but is entirely an administrative decision concerning eligibility under or coverage of an ERISA plan, it is preempted.

*Id.* at 852. Applying this rule, the court held that the action before it—which involved a determination that the plaintiff was not disabled, *see id.* at 847-48—was preempted, because Maryland malpractice law required a "relationship of doctor

and patient as a result of a contract . . . that the doctor will treat the patient." *Id.* at 852. But the plaintiff had no such relationship with the benefits administrator; rather, the administrator "was acting entirely within his capacity as a fiduciary under the Plan." *Id.* at 853.

The conflict does not end with the lower courts, as the United States has also published its views on the preemption issue in a brief submitted to this Court. Specifically, in its *amicus* brief signed by the Solicitor General and the Solicitor of the Department of Labor and filed in *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021, 2001 WL 1480556 (filed Nov. 7, 2001), the United States argued that state law challenges to eligibility decisions under benefit plans should be preempted "even if the subject of the decision is 'medical necessity' and the decisionmaker is a physician." *Id.* at *10; *see also id.* at *8-9 (discussing *Pegram*). With regard to *Pegram*, the United States stated that:

> Some statements in *Pegram*, if read in isolation, might suggest that such "mixed decisions" . . . are never fiduciary acts under ERISA, regardless of whether they are made by the treating physician or by another physician who is ruling on a beneficiary's internal appeal of the denial of her claim. If so, there might then be a question whether a state law governing mixed decisions "relates to" ERISA plans at all. The better reading of *Pegram*, however, is that it addresses only mixed decisions made by treating physicians. *Pegram* grew out of such a decision by the plaintiff's treating physician.

*Id.* at 8.

Not surprisingly, much has already been written about the confusion and conflict that has arisen in *Pegram*'s wake. Discussing this case, Carter Phillips has called ERISA "a nightmare," and its preemption provision "largely imponderable." David Hechler, *After ERISA Decision, Confusion Remains*, N.Y.L.J., Mar. 6, 2003, at 5 (quoting

Carter Phillips). Other practitioners have offered that "[t]he bottom line is the courts are split on this issue about how to read *Pegram*, and whether there is pre-emption where there is a mixed medical and eligibility decision." Judy Greenwald, *Court may revisit* Pegram*; Interpretations muddy waters on HMO ruling*, BUS. INS. at 1 (Oct. 8, 2001).

This conflict, moreover, will not resolve itself over time but will worsen. There is no reason to expect that the Second Circuit will reconsider its *Cicio* decision. The court denied a motion to rehear the case *en banc* despite Judge Calabresi's dissenting vote, and the court has since cited *Cicio* as settled circuit precedent. *See Gerosa v. Savasta & Co.*, 329 F.3d 317, 326 n.7 (2d Cir. 2003); *Rubin-Schneiderman v. Merit Behavioral Care Corp.*, 60 Fed. Appx. 887, 887 (2d Cir. Apr. 18, 2003) (remanding to district court in light of *Cicio*). Courts on the other side of the preemption issue, moreover, have expressly rejected the Second Circuit's reasoning. *See, e.g.*, *Pryzbowski*, 245 F.3d at 274-75; *Haynes*, 313 F.3d at 536. So has the United States in its *amicus* brief in *Rush*. In short, even though *Pegram* was decided just a few years ago, its *dicta* has already deeply divided and confused the lower courts, and the arguments on every side of the issue have been well ventilated. This Court's immediate review of the preemption issue is thus necessary and appropriate.

## II. THE QUESTION PRESENTED IS A RECURRING ONE OF NATIONAL IMPORTANCE THAT REQUIRES IMMEDIATE RESOLUTION.

Beyond implicating a split of authority, the question presented is one of national importance that arises with great frequency. Failure to resolve the issue promptly will undermine the uniformity objective of ERISA, waste substantial judicial resources, and have a deleterious impact on health care coverage.

There can be no serious debate that ERISA preemption questions have great national importance. This Court has

characterized the policy underlying ERISA preemption—"uniform national treatment" of benefits—as one of great importance. *See Patterson v. Shumate*, 504 U.S. 753, 765 (1992). Indeed, the Court has recognized that "ERISA pre-emption questions are recurrent" precisely because of "the comprehensive nature of the statute, the centrality of pension and welfare plans in the national economy, and their importance to the financial security of the Nation's work force." *Boggs v. Boggs*, 520 U.S. 833, 839 (1997).

The particular preemption question presented here—whether state law claims challenging alleged medically-based eligibility determinations are preempted—is especially important, because so many coverage decisions involve medical determinations. *See* R. Rosenblatt, *et al.*, LAW & THE AMERICAN HEALTH CARE SYSTEM 211-12, 568-70 (1997). For example, benefit administrators frequently make decisions about the efficacy of medical procedures, whether procedures are experimental and/or whether a procedure is medically necessary. *Id.* at 211-15. Moreover, because of the rate of technological change and scientific and medical experimentation, as well as the growth of healthcare fraud and unduly defensive medical practice, novel eligibility and coverage questions involving benefit provisions of this type arise with great frequency. *Id.* at 19, 212-13. Accordingly, the question presented here affects literally thousands of benefit plans and millions of healthcare decisions by benefit administrators. Indeed, in the three years since *Pegram* was decided, eight courts of appeal and state courts of last resort have already opined on this preemption question. And the same issue is pending in or has recently been decided by numerous district courts as well. *See Land v. Cigna Healthcare*, No. 02-15549EE (11th Cir. notice of appeal filed Oct. 7, 2002); *Waldschmidt v. Aetna U.S. Healthcare*, 225 F. Supp. 2d 560, 565-66 (W.D. Pa. 2002); *Isaac v. Seabury & Smith, Inc.*, No. IP0-1-C1437 B/S, 2002 WL 1461710, at *1 (S.D. Ind. July 5, 2002); *Tanous v. United Behavioral Health*,

No. 8:01CV297, 2002 WL 378508, at *1-*2 (D. Neb. Mar. 12, 2002); *Tran v. Kaiser Found. Health Plan of Tex.*, No. Civ.A. 300CV1559P, 2001 WL 1082418, at *6 (N.D. Tex. Sept. 7, 2001); *Schusteric v. United Healthcare Ins. Co. of Ill.*, No. 00 C 4156, 2000 WL 1263581, at *2 (N.D. Ill. Sept. 5, 2000); *Rivers v. Health Options Connect, Inc.*, 96 F. Supp. 2d 1370, 1373 (S.D. Fla. 2000).

For this reason, the Solicitor General in his petition-stage *amicus* brief in *Rush* characterized the preemption issue here as one "of very broad significance." *See Rush Prudential, Inc. v. Moran*, No. 00-1021 (Br. filed May 31, 2001). Consistent with this observation, in the court below, five national and state organizations—the American Medical Association, the American College of Legal Medicine, the Medical Society of the State of New York, the American Association of Health Plans, and the New York Health Plan Association—signed *amicus* briefs addressing this preemption question. Finally, both legal academics and national news commentators have opined on the importance of the issue:

> the significance of the holding by the Second Circuit cannot be overstated. Its broad interpretation of *Pegram* and its protection of state law causes of action regarding medical practice and health care are monumental.

Thomas A. Moore & Matthew Gaier, *Recent Second Circuit Decision on HMO Liability*, N.Y.L.J., Mar. 10, 2003, at 3; *see also* Roni Rabin, *HMO Can Be Sued*, NEWSDAY, Feb. 21, 2003, at A4 (calling *Cicio* a "significant" ruling that "touches on a key controversy"); Leo T. Crowley, *Door Opens for Malpractice Claims to Outlast Preemption Disputes*, N.Y.L.J., Mar. 6, 2003, at 3 (observing that *Cicio* decision "creates a huge gap in the once-formidable wall of ERISA preemption"); Robert Pear, *A Court Expands the Rights of Patients to Sue HMO's*, N.Y. TIMES, Feb. 18, 2003, at A14 (observing that decision greatly "expanded patients' rights"); M. Freudenheim, *A Court says Insurance Companies Should*

*be Accountable for Damage to a Patient's Health*, N.Y. TIMES, Feb. 20, 2003, at C7 (quoting Dr. Richard Corlin that "[*Cicio*] is a very important case in which the highest court in the country below the Supreme Court has completely pierced ERISA.").

The Court should not delay in resolving the issue and the conflict over it. Every day that the conflict is allowed to persist, ERISA's goal of "set[ting] forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans" is undermined. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). The state of the law in Pennsylvania amply demonstrates how harmful this disuniformity can be: In that State, citizens and health plans are subject to plainly inconsistent legal standards, depending upon whether they are in federal or state court. *Compare Pryzbowski*, 245 F.3d at 273 *with Pappas*, 768 A.2d at 1095. Moreover, the diversity in judicial opinion about this issue creates an incentive for forum shopping and for arbitrary legal results, since benefit plans cover employees who may work and/or reside in a multi-State area.

In addition, as this Court has recognized, continuing legal uncertainty harms plan participants by causing employers to reduce or eliminate coverage. *See Pilot Life*, 481 U.S. at 54; *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262-63 (1993). One expert in this field has explained (in discussing this precise preemption question) that "[a]ny increase in costs as well as the uncertainty that accompanies litigation will force employers to confront the costs associated with the potential for large damage awards or settlements, and would discourage them from including broad categories of coverage, or from even sponsoring coverage for their employees altogether." Stephanie Kanwit, *Should HMO Coverage Decisions be Subject to Medical Malpractice Lawsuits? No: It Makes No Sense*, THE REGULATOR, May 2003, at 12. Indeed, failing to

review the question presented now would waste tremendous private and judicial resources, as numerous district courts consider the same recurring issue and render deeply conflicted decisions.

This case is an excellent vehicle for the Court to use in resolving this ERISA preemption question. The court below considered and rejected ERISA preemption under *both* § 502(a) and § 514(a), thus allowing the Court to consider the entire preemption issue in a single case. Both the § 502(a) and § 514(a) questions were cleanly presented to the lower court, and there are no procedural or jurisdictional issues that might preclude the Court's review. Moreover, the Second Circuit expressly acknowledged the conflict in this area, and its decision was issued over a forceful and informative dissent by Judge Calabresi. In short, the time has come for the Court to resolve the ERISA preemption question presented, and this case is the proper medium through which to do so.

## III. THE SECOND CIRCUIT ERRED IN CONCLUDING THAT CICIO'S CLAIM IS NOT PREEMPTED BY ERISA.

The Court should also be concerned to correct the error of the court below. The Second Circuit's holding that state law claims challenging alleged medically-based eligibility determinations are not preempted is, as Judge Calabresi argued, contrary to ERISA's structure and the overwhelming precedent of this Court.

**First**, the lower court's determination that these state law claims are not preempted under § 514(a) of ERISA is erroneous. Section 514(a) provides, in relevant part, that ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan." 29 U.S.C. § 1144(a). A state law medical malpractice action challenging an eligibility determination, even one that involves medical judgment, is plainly such a law.

A benefit plan within the meaning of ERISA is "a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan." *Pegram*, 530 U.S. at 223. Moreover, this Court has said that a state law "relate[s] to" such a benefit plan if it "has a connection with or reference to [the] plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983). Under the latter inquiry, the Court has held preempted laws that "impos[e] requirements by reference to [ERISA] covered programs," *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130-31 (1992), and laws that establish the existence of an ERISA plan as the "critical factor in establishing liability under the State's [law]." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139-40 (1990). With respect to the former inquiry, this Court has suggested that it should be understood in a "broad sense." *Shaw*, 463 U.S. at 98. Of course, more recently, the Court has made clear "that an 'uncritical literalism' in applying this standard offer[s] scant utility in determining Congress' intent as to the extent of § 514(a)'s reach." *Calif. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997) (quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995)). "Rather, to determine whether a state law has the forbidden connection, [the Court] look[s] both to 'the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive,' as well as to the nature of the effect of the state law on ERISA plans." *Id.* (quoting *Travelers*, 514 U.S. at 656) (internal citation omitted).

Regardless of the exact approach to § 514(a) preemption this Court has applied, it has *always* recognized that state law claims like the one asserted here—that directly implicate the construction and administration of the benefits plan—are

preempted. In *Shaw*, for example, the Court held that the New York Human Rights Law, which prohibited employers from establishing benefit plans that discriminated on the basis of pregnancy, was preempted because the law had the effect of "requir[ing] employers to pay employees specific benefits." *Shaw*, 463 U.S. at 97. In the first half of this Court's decision in *Pilot Life*, 481 U.S. at 48, the Court concluded that common law claims "based on alleged improper processing of a claim for benefits under an employee benefit plan, *undoubtedly* meet the criteria for pre-emption under § 514(a)." *Id.* (emphasis supplied). More recently, in *Rush*, the Court, considering a case involving whether a proposed treatment was "medically necessary," observed that a state law requiring independent review of disputes between HMOs and primary care physicians over the "medical necessity" of a treatment was "beyond serious dispute" a law that "relates to employee benefit plans within the meaning of [§ 514(a)]" because it required HMOs "to submit to an extra layer of review for certain benefit denials." 536 U.S. at 365.

The state law cause of action at issue here—a malpractice action challenging an alleged improper determination of whether a medical procedure was covered under an employee benefit plan—is no different in kind or degree from these preempted state laws. Like the common law claim at issue in *Pilot Life*, the claim here is based on an allegation that some alleged benefit was improperly denied. And Cicio's claim, like the Illinois law at issue in *Rush*, seeks to add another layer of review on top of benefit denials involving medical judgments, only this time the review sought is by a court rather than an arbitrator. Ultimately, the dispute here turns on the rules regarding "definition of benefits," which is part and parcel of a benefit plan. *Pegram*, 530 U.S. at 223.

There is, moreover, no exception to § 514(a) preemption applicable here that might save Cicio's claims from preemption. Unlike the law at issue in *Rush*, which this Court ultimately held was saved from preemption because it

regulated insurance, common law tort principles governing medical malpractice claims are not such insurance regulations. Indeed, this Court has repeatedly held that a "common law of general application . . . is not a law regulating insurance" within the meaning of ERISA's savings clause. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 62 (1987); *see Pilot Life*, 481 U.S. at 51 (rejecting argument that state law bad faith claim was an insurance regulation because it "has developed from general principles of tort and contract law.").

**Second**, Cicio's claims are also preempted under § 502(a). This section provides a federal remedy for "a participant or beneficiary" of an employee benefit plan "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). As this Court has recognized, if an action under state law falls within § 502(a)'s scope, it is preempted to the extent the state law entitles a plan participant to remedies that are not provided for in § 502(a). *Rush*, 536 U.S. at 379 (observing that any law that "provided a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA . . . . patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct").

Clearly, state law claims, such as Cicio's, which allege that benefits were improperly denied as a result of a mistaken medical judgment by a non-treating physician, fall within the scope of § 502(a)(1)(B). Indeed, this case is little different from *Metropolitan Life*. In that case, this Court held that tort and contract law claims arising from an alleged improper determination that an employee was not disabled, and not entitled to disability benefits, fell "directly under § 502(a)(1)(B) of ERISA," because the suit was "by a beneficiary to recover benefits from a covered plan." 481 U.S. at 62-63. Cicio's claim is analytically indistinguishable.

In addition, the remedies that Cicio seeks, consequential and punitive damages in excess of $220 million, are not authorized under § 502(a). *See Mertens*, 508 U.S. at 261-63. Allowing Cicio's action to proceed would thus impermissibly alter the remedies provided under ERISA. As Judge Calabresi observed, the Supreme Court "has moved more and more in the direction of barring only those state actions which, if local law were permitted to govern, would expand (or contract) the relief available beyond that provided by § 502(a) of ERISA," but "[e]ven accepting this more limited . . . scope of preemption, where does that leave Mrs. Cicio's suit? . . . . I regretfully conclude that it is barred." Pet. App. 41a.

**Third**, the Second Circuit improperly read *Pegram* to save state law causes of action challenging alleged medically-based eligibility determinations. *Pegram* was not even an ERISA preemption case. The sole issue that *Pegram* addressed was whether a "mixed eligibility" decision was a fiduciary act under ERISA. Moreover, in *Pegram*, this fiduciary act question arose in a context where a *single* physician functioned both as the treating physician and as the administrator rendering eligibility determinations. *Pegram*, 530 U.S. at 237. This case, in contrast, asks whether ERISA preempts a state law action challenging an eligibility determination by a *non-treating* physician.

To be sure, there is (as Judge Calabresi characterized it) some "unexplained" and "well intentioned *dicta*" in *Pegram* (Pet. App. 43a) which could be read to suggest that, when a benefit plan administrator makes any sort of eligibility determination that requires medical judgment, it never acts as a fiduciary under ERISA. *See id.* at 231. But this is not, as the Solicitor General has argued, the proper way to read *Pegram*'s *dicta*. *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021, 2001 WL 1480556, at *8 (filed Nov. 7, 2001) (emphasis supplied). *Id.* "The better reading of *Pegram*, . . . is that it addresses only mixed decisions *made by treating physicians*." *Id.* (emphasis added).

In any event, the Court's *dicta* in *Pegram* provides no guidance here. *Pegram*'s *dicta*, including its remarks about a "puzzling issue" of ERISA preemption, concerned whether application of ERISA's fiduciary duty provisions to "mixed eligibility" decisions would work a preemption of state malpractice claims. *See* 29 U.S.C. § 1109(a). Nothing in the opinion speaks to the distinct ERISA preemption question here—to wit, whether a challenge to a benefits coverage determination is preempted by the provisions of §§ 502 and 514 of ERISA that make enforcement of the terms of an employee benefit plan the exclusive province of federal law. *See id.* §§ 1132(a)(1)(B); 1144(a). Whether a "mixed eligibility" decision is a fiduciary act or not, a coverage determination is in all events a construction of the terms of a benefit plan within the scope of § 514(a) for which ERISA provides a direct cause of action under a provision of § 502—a cause of action that is separate from the statute's fiduciary duty and enforcement provisions. For this reason, *Pegram*'s *dicta* about the scope of fiduciary duties (and related preemption issues) is wholly inconclusive of the distinct ERISA preemption question presented here.

Of course, *Pegram*'s concern about not unnecessarily preempting state medical malpractice law is implicated here too. But there is no suggestion being made here that a state law challenge to a physician's *treatment* decision is preempted under ERISA. Rather, the suggestion made here is simply that *coverage* determinations themselves are at the heart of ERISA and that state law challenges to coverage decisions are preempted, whether they involve medical considerations or not. *Pegram*'s discussion of fiduciary duties and related preemption questions simply do not address, much less answer, this fundamentally different question.

## CONCLUSION

For these reasons, the petition for a writ of *certiorari* should be granted.

Respectfully submitted,

CHARLES G. MOERDLER
STROOCK & STROOCK
& LAVAN LLP
180 Maiden Lane
New York, NY 10038
(212) 806-5400

*Of Counsel*

GLEN D. NAGER
(*Counsel of Record*)
TRACI L. LOVITT
JONES DAY
51 Louisiana Ave., N.W.
Washington, D.C. 20001
(202) 879-3939

*Counsel for Petitioners*

July 11, 2003

# APPENDIX

321 F.3d 83

**United States Court of Appeals,**
**Second Circuit.**

Bonnie CICIO, individually and as Administratrix of the Estate of Carmine Cicio, Plaintiff-Appellant,

v.

John DOES 1-8, Defendants,
Vytra Healthcare, and Brent Spears, M.D.,
Defendants-Appellees.

Docket No. 01-9248.

Argued: June 20, 2002

Decided: Feb. 11, 2003.

As Amended: March 12, 2003.

Before: CALABRESI, SACK, and B.D. PARKER, Jr., Circuit Judges.

Judge CALABRESI dissents in part in a separate opinion.

SACK, Circuit Judge.

Plaintiff Bonnie Cicio appeals from an October 4, 2001 judgment of the United States District Court for the Eastern District of New York (Joanna Seybert, *Judge*) denying her motion to remand her action to New York Supreme Court, and granting the Fed. R. Civ. P. 12(b)(6) motion of the defendants Vytra Healthcare ("Vytra") and Dr. Brent Spears to dismiss the complaint for failure to state a claim upon which relief can be granted. *Cicio v. Vytra Healthcare*, 208 F. Supp. 2d 288, 293 (E.D.N.Y. 2001). The district court, adopting the March 13, 2001 report and recommendation of Magistrate Judge E. Thomas Boyle, *id.* at 293, held that all of the plaintiff's claims, which derive from the defendants-appellees' decision to deny the plaintiff's

deceased spouse, Carmine Cicio, preauthorization for a requested medical procedure, were preempted by the Employee Retirement Income Security Act of 1974, 88 Stat. 832, as amended, 29 U.S.C. § 1001 *et seq.* ("ERISA"). *Cicio*, 208 F. Supp. 2d at 293. The plaintiff now appeals on the sole ground that her claims are not preempted by ERISA.

We agree with the plaintiff that the district court erred in dismissing the medical malpractice claims at this stage of the proceedings. We conclude, however, that the district court correctly dismissed the plaintiff's claims that are based on the defendants' alleged misrepresentations or alleged negligence in delaying a coverage decision with respect to Mr. Cicio's medical care. Accordingly, we affirm in part and remand in part.

## BACKGROUND

*Carmine Cicio's Illness and Treatment*

Because this case comes to us on appeal from the grant of a motion to discuss under Fed. R. Civ. P. 12(b)(6), we review the facts as they have been alleged by the plaintiff. *See, e.g., ICOM Holding, Inc. v. MCI Worldcom, Inc.*, 238 F.3d 219, 221 (2d Cir. 2001). In March 1997, the plaintiff's spouse, Carmine Cicio, was diagnosed with multiple myeloma.[1] He began chemotherapy the following month. At that time, both he and the plaintiff received health care benefits pursuant to an "Agreement for Comprehensive Health Services" (the "Plan") administered by Vytra, an "Individual Practice Association-Health Maintenance

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[1] "Multiple myeloma is the second most prevalent blood cancer and represents approximately 1% of all cancers and 2% of all cancer deaths." Multiple Myeloma Research Foundation, *The Statistics*, *at* http://www.multiplemyeloma.org/aboutmyeloma/statistics.html (last visited September 16, 2002).

Organization."[2] The plaintiff's employer, North Fork Bank, had purchased the Plan from Vytra. The Plan, it is now undisputed, is an "employee benefit plan," as defined in 29 U.S.C. § 1002(3) of ERISA.[3]

The Plan's subscriber agreement explains that Vytra provides Plan enrollees with, *inter alia*, "[d]iagnosis and treatment of disease, injury or other conditions." Agreement for Comprehensive Health Servs. Art. III, § 3.1(b). The Plan cautions, however, that "Vytra shall provide only Medically Necessary Vytra Services . . . ." *Id.* Art. III, § 3.5(a). Vytra

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[2] An independent practice association is a "local physician group . . . comprised of physicians who are active on [a] hospital's medical staff" and contract with a health maintenance organization to provide medical services. Kenneth R. Wing *et al.*, *The Law and American Health Care* 1005-06 (1998) (citing Carl H. Hitchner *et al.*, *Integrated Delivery Systems: A Survey of Organizational Models*, 29 WAKE FOREST L. REV. 273, 275 (1994)). Health Maintenance Organizations ("HMOs") are entities that "offer a form of health insurance [that differs from traditional medical insurance] . . . . HMOs are not guaranteeing to *reimburse* the insured for medical expenses; rather, their obligation to the insured is more direct—to actually *provide* medical services to them." *Id.* at 77 (internal citation omitted; emphasis in original); *see also Pegram v. Herdrich*, 530 U.S. 211 (2000) ("The defining feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed.").

In an "Individual Practice Association-Health Maintenance Organization," "physicians' services are established with a relatively large number of generally small or medium-sized group practices, with physicians receiving some type of discounted fee-for-service payment from the HMO, rather than . . . . salaried reimbursement . . . ." *Id.* at 81 (internal citation omitted).

[3] A plan within the meaning of ERISA is "a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan." *Pegram*, 530 U.S. at 223. Here, the "Agreement for Comprehensive Health Services" fulfills that function.

also disclaims the obligation to provide "[a]ny procedure or service which, in the judgment of Vytra's Medical Director, is experimental or is not generally recognized to be effective for a particular condition, diagnosis, or body area . . . ." *Id.* Art. IX, § 9.3(f).

On January 28, 1998, some ten months after Carmine Cicio's disease was first diagnosed, his treating oncologist, Dr. Edward Samuel, wrote a detailed letter to Vytra "request[ing] insurance approval for treatment of Mr. Cicio with high dose chemotherapy supported with peripheral blood stem cell transplantation, in a tandem double transplant, for a diagnosis of multiple myeloma."[4] Letter from Edward T. Samuel to Vytra dated January 28, 1998, at 1. Dr. Samuel set forth Carmine Cicio's clinical history and prior treatments, including one type of chemotherapy that had failed, before explaining why "a change in strategy of treatment . . . had to be made." *Id.* And Dr. Samuel explained why he thought that Mr. Cicio was a good "candidate" for the transplant. *Id.* at 2.

Almost a month later, in a letter dated February 23, 1998, Vytra's medical director, the defendant Dr. Spears, denied Dr. Samuel's request, stating only that the procedure sought was "not a covered benefit according to this member's plan which states [that] experimental/investigational procedures are not covered." Letter from Brent W. Spears to Edward T. Samuel dated February 23, 1998, at 1. On March 4, after unsuccessful attempts to contact Dr. Spears by telephone,

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[4] A peripheral blood stem cell transplantation is "[a] procedure in which blood containing mobilized stem cells is collected by apheresis [a procedure in which blood is removed from a donor, a blood component, *e.g.*, white blood cells, is separated out, and the remaining blood is reinfused back into the donor], stored, and infused following high-dose chemotherapy or radiation therapy." Multiple Myeloma Research Foundation, *Myeloma Dictionary*, *at* http://www.multiplemyeloma.org/aboutmyeloma/defs.html (last visited September 16, 2002).

Dr. Samuel wrote Dr. Spears "appealing to [him] to reconsider [his] decision." Letter from Edward T. Samuel to Brent W. Spears dated March 4, 1998, at 1-2. Dr. Samuel argued that

> The treatment of multiple myeloma by high-dose chemotherapy/autologous stem cell transplantation is a well-established method of treatment with a superior response rate, complete response rate, post therapy disease-free interval, and possibly even a long-term cure in some patients, as compared to standard therapies. These facts are true for single transplant methodologies, and the statistical response rate and CR rates are improved even further with double transplants.

*Id.* He further argued, based on medical literature listed in his letter, that "treatment NOW with high-dose chemotherapy and autologous stem transplant . . . offers [Mr. Cicio] better chances of survival than any other available method of treatment." *Id.* at 2 (emphasis in original). While this letter made the one reference to "single transplant methodologies" quoted above, it made clear that Dr. Samuel viewed that procedure as a less appropriate treatment for Mr. Cicio than a double stem cell transplant and was not requesting approval for it. *Id.* at 1.

Three weeks later, in a letter dated March 25, 1998, Dr. Spears tersely replied that "[b]ased on the clinical peer review of the additional material, [presumably the studies referenced by Dr. Samuel in his March 4 letter,] a single stem cell transplant has been approved" but "the original request for [a] tandem stem cell transplant remains denied." Letter from Brent W. Spears to Edward T. Samuel dated March 25, 1998, at 1. Mr. Cicio, who, according to the complaint, was by March 25 no longer a candidate for a stem cell transplant, died less than two months later, on May 11, 1998. Compl. ¶ 31.

*The Complaint*

Bonnie Cicio filed a complaint, on behalf of herself and the estate of her late husband, in New York Supreme Court, Suffolk County, naming Vytra, Dr. Spears, and eight unknown physicians employed by Vytra ("John Does 1-8") as defendants. The complaint contains eighteen counts alleging "medical malpractice, negligence, gross negligence, intentional infliction of emotional distress, negligent infliction of emotional distress, misrepresentation, breach of contract, bad faith breach of insurance contract and violation of New York State law" based on Dr. Spears's denial of treatment to Mr. Cicio.

On May 30, 2000, the defendants removed the proceedings from New York state court to the United States District Court for the Eastern District of New York pursuant to 28 U.S.C. § 1441. On June 21, 2000, they filed a Rule 12(b)(6) motion to dismiss the complaint for failure to state a claim.

*The Magistrate Judge's Report and Recommendation and the District Court's Decision*

The case was referred by the district court to Magistrate Judge E. Thomas Boyle, who (1) found that removal jurisdiction obtained, and (2) recommended that the defendants' Rule 12(b)(6) motion be granted. *Cicio*, 208 F. Supp. 2d at 294-302. Magistrate Judge Boyle reasoned that the plaintiff's state law claims were preempted under §§ 502(a) and 514(a) of ERISA, 29 U.S.C. §§ 1132(a)(1)(B) & 1144(a), because the plaintiff sought "to enforce the terms of [an employee welfare benefit] plan" and that her claims were "within the scope of" § 502(a). *Cicio*, 208 F. Supp. 2d at 296-301. He concluded that both removal and dismissal were therefore required. *Id.* at 302. He also recommended that the plaintiff's state law deceptive business practices claim be dismissed because it was "exceedingly vague." *Id.* at 301-02.

In so concluding, the magistrate judge rejected several counter-arguments proffered by Ms. Cicio. First, he rejected her argument that Vytra's Agreement for Comprehensive Health Services was not a "plan" governed by ERISA. *Id.* at 297. Then he declined to endorse the plaintiff's argument that her medical malpractice claims were not preempted because they concerned "mixed eligibility and treatment decisions," as described in *Pegram v. Herdrich*, 530 U.S. 211, 229 (2000). *Cicio*, 208 F. Supp. 2d at 300-01. While many decisions by health insurance providers "involve[ ] some medical judgment," Magistrate Judge Boyle said, "[t]here is no evidence that Congress intended that these quasi-medical/administrative decisions made by a plan administrator survive ERISA preemption." *Id.* Even if such malpractice claims were not preempted, Magistrate Judge Boyle continued, Ms. Cicio had not challenged "the quality of the care but rather . . . the benefits decision that was made," and hence had alleged the kind of claim that ERISA preempted. *Id.* at 301.

The plaintiff formally objected to the magistrate judge's report and recommendation. The district court nonetheless adopted it in full. *Id.* at 291. The court agreed that Vytra's health plan was a "benefit plan" as defined by ERISA. *Id.* at 292. The court also disagreed with the renewed contention that under *Pegram*, claims for improper medical care are not preempted by ERISA. It concluded instead that because all of the plaintiff's malpractice claims "involve[d] eligibility for coverage," such that the "[d]efendants' roles, including that of Dr. Spears, were administrative," these claims concerned benefits decisions and thus were also preempted. *Id.* at 293.

The plaintiff appeals.

## DISCUSSION

### I. Standard of Review

We review a district court's denial of a motion to remand *de novo*. *Whitaker v. Am. Telecasting, Inc.*, 261 F.3d 196, 201 (2d Cir. 2001). We also review the district court's decision to grant a Rule 12(b)(6) motion *de novo*. *Kalnit v. Eichler*, 264 F.3d 131, 137-38 (2d Cir. 2001). Dismissal is not warranted unless "no relief could be granted under any set of facts that could be proved consistent with the allegations." *Hishon v. King & Spalding*, 467 U.S. 69, 73 (1984). We thus "tak[e] all factual allegations in the [verified] complaint as true and constru[e] all reasonable inferences in favor of plaintiffs." *Conboy v. AT & T Corp.*, 241 F.3d 242, 246 (2d Cir. 2001) (citing *Conley v. Gibson*, 355 U.S. 41, 45-46 (1957)).

### II. The Nature of the Plaintiff's Claims

Because the plaintiff asserts a variety of claims, we must first determine which of them remain on appeal. We note initially that the plaintiff's deceptive business practices claim and contract claims are no longer before us. The magistrate judge rejected the former, *see* Compl. ¶¶ 127-29, as excessively vague, *Cicio*, 208 F. Supp. 2d at 301-02, a conclusion Ms. Cicio does not challenge on appeal. And in her brief to us, Ms. Cicio renounces her breach of contract claim and bad faith breach of insurance contract claim. Plaintiff-Appellant's Br. at 1. Finally, although Ms. Cicio asserts causes of action for what she calls tortious interference with the physician-patient relationship, Compl. ¶¶ 69-76, breach of fiduciary duty, *id.* ¶¶ 77-81, negligent supervision of employees, *id.* ¶¶ 103-06, and negligent and intentional infliction of emotional distress, *id.* ¶¶ 107-17, the facts underlying these theories of recovery are entirely subsumed within her other negligence claims. We therefore treat these causes of action as alternative pleadings of her remaining medical malpractice and negligence claims.

The claims thus remaining on appeal pertain in substance to (1) the timeliness of Dr. Spears's decisions relating to Mr. Cicio's treatment, *see* Compl. ¶¶ 58-81; (2) the allegedly misleading nature of Vytra's representations about the Plan, *see* Compl. ¶¶ 82-102; and, (3) the quality of the medical decision, if any, made by the defendants with respect to Mr. Cicio's treatment, *see* Compl. ¶¶ 33-57, 103-17.[5] Both the magistrate judge, *Cicio*, 208 F. Supp. 2d at 301, and the district court, *id.*, determined that the complaint did not challenge the quality of the medical decision because "all of the Plaintiff's state law claims center on Vytra's refusal to approve coverage and thus stem from an adverse benefits determination," *id.* We disagree.

A Rule 12(b)(6) dismissal "is inappropriate unless it appears beyond doubt, even when the complaint is liberally construed, that the plaintiff can prove no set of facts which would entitle [her] to relief." *Sec. Investor Prot. Corp. v. BDO Seidman, LLP*, 222 F.3d 63, 68 (2d Cir. 2000) (internal citation and quotation marks omitted). Under this broad standard, Ms. Cicio's complaint identifies a medical decision that may be the predicate for a state-law medical malpractice claim.

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[5] We disagree with the defendants' suggestion that the plaintiff failed to perfect an appeal of the magistrate judge's report and recommendation. "A party must serve and file any objections to a magistrate judge's proposed findings and recommendations within ten days after being served with the report . . . . [F]ailure to object timely to a report waives any further judicial review of the report." *Frank v. Johnson*, 968 F.2d 298, 300 (2d Cir.) (citing 28 U.S.C. § 636(b)(1)), *cert. denied*, 506 U.S. 1038 (1992). Ms. Cicio filed her objection, that the magistrate judge's report and recommendation was "clearly erroneous," within ten days after the report was filed, hence meeting her obligation under 28 U.S.C. § 636(b)(1) and Fed. R. Civ. P. 72(a). Our cases have mandated no further specification of the basis for objection, and we decline to require additional detail in a timely objection to a magistrate judge's report and recommendation.

The complaint alleges that Dr. Spears and other physicians employed by Vytra "failed to exercise the degree of care required of them and were negligent in the provision and delivery of medically necessary care." Compl. ¶ 56. It is possible that in attacking Dr. Spears's determination that a "tandem double stem cell transplant" was an "experimental/investigational procedure[ ]," Ms. Cicio is questioning only Dr. Spears's assessment of the then-current state of medical science without regard to Mr. Cicio's particular medical affliction. This kind of decision about the scope of generally available benefits lacks a significant application of medical judgment to Mr. Cicio's case and, as the district court correctly noted, would be treated as a decision simply about the scope of benefits. But correspondence between Drs. Samuel and Spears attached to the complaint, *see* Compl. ¶¶ 15, 19, 26 & 29, and incorporated therein by reference,[6] described above, strongly suggests that Ms. Cicio is contending additionally or in the alternative that Dr. Spears, in making negligent medical decisions about Mr. Cicio's condition, was engaged in medical malpractice. The liberal construction we are required to give the complaint requires us to consider this understanding of the allegations it contains.

In his request for approval for treatment dated January 28, 1998, Dr. Samuel provided Vytra's Medical Director, Dr. Spears, with a thorough description of the case history of Mr. Cicio's illness. Letter from Edward T. Samuel to Vytra dated January 28, 1998, at 1-3. This information at least permitted Dr. Spears to make a medical determination regarding Mr. Cicio's treatment on the basis of his aggregate symptoms. And while Dr. Spears stated in reply only that

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[6] *See* Fed. R. Civ. P. 10(c) ("Statements in a pleading may be adopted by reference in a different part of the same pleading or in another pleading or in any motion. A copy of any written instrument which is an exhibit to a pleading is a part thereof for all purposes.").

the requested "procedure is not a covered benefit according to this member's plan," Letter from Brent W. Spears to Edward T. Samuel dated February 23, 1998, at 1, his decision could have rested *either* on an analysis of the appropriate treatment for Mr. Cicio's specific condition, *or* on whether in the abstract a double stem cell transplant to treat multiple myeloma was experimental given the current state of the medical art. Therefore, there is at least a possibility that the February 23rd letter reflected a medical decision.

The impression that the February 23rd letter may have embodied a medical decision is strengthened by the subsequent correspondence. Dr. Samuel's response stressed the appropriateness of double stem cell transplants in light of Mr. Cicio's particular symptoms. Dr. Spears's answer, that "[b]ased on the clinical peer review of the additional information, a single stem cell transplant has been approved [but] the original request for tandem stem cell transplant remains denied," Letter from Brent W. Spears to Edward T. Samuel dated March 25, 1998, at 1, appears to reflect a decision about an appropriate level of care. By denying one treatment and authorizing another that Dr. Samuel had not specifically requested, Dr. Spears at least seems to have been engaged in a patient-specific prescription of an appropriate treatment, and, ultimately, a medical decision that a single stem cell transplant was the appropriate treatment for Mr. Cicio.

At this stage of the litigation, reading the plaintiff's complaint and the attachments thereto together, then, we conclude that the plaintiff has alleged that the defendants made a decision that could implicate a state law duty concerning the quality of medical decision-making, in addition to and independent of her claims concerning the administration of benefits with respect to her late husband's course of care.

We do not, however, draw any conclusion about the availability of a malpractice claim in these circumstances under New York law, or whether any of the elements of such a claim, if it exists, would be satisfied by the facts as alleged in this case. We conclude only that, for the purposes of this Rule 12(b)(6) motion, the plaintiff has alleged more than an adverse benefits decision. She has also alleged that the defendants made a negligent medical determination with respect to the treatment of her late husband.

## III. Subject Matter Jurisdiction

The district court concluded that defendants' removal of the complaint to federal court was proper. We agree.

### A. Removal Jurisdiction

Pursuant to 28 U.S.C. § 1441(b), under which this case was removed from state to federal court, "[a]ny civil action of which the [federal] district courts have original jurisdiction [under 28 U.S.C. § 1331] . . . shall be removable . . . ." Section 1331 in turn provides that "[t]he district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States." 28 U.S.C. § 1331.

Thus, "a defendant may not remove a case to federal court [pursuant to § 1441(b)] unless the plaintiff's complaint establishes that the case 'arises under' federal law." *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 10 (1983) (emphasis omitted); *accord Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987) ("It is long settled law that a cause of action arises under federal law only when the plaintiff's well-pleaded complaint raises issues of federal law."). But all eighteen causes of action in Ms. Cicio's complaint sound in New York, not federal, law. And while the defendants' principal defense here rests on federal preemption grounds, if "the only question for decision [was] raised by a federal preemption defense" against a state law

claim, no "arising under" subject matter jurisdiction would exist. *Franchise Tax Bd.*, 463 U.S. at 12. Removal to federal district court would, in such circumstances, be improper.

Ms. Cicio's complaint may nonetheless establish § 1331 subject matter jurisdiction pursuant to federal courts' ability to "recharacterize a state law complaint" as "arising under" federal law, *Taylor*, 481 U.S. at 64, under the "complete preemption" doctrine of jurisdiction. "[W]hen Congress mandates 'complete preemption' in a specific area of the law, any civil complaint raising a state law claim in that area is of necessity so federal in character that it arises under federal law . . . and permits removal to federal court under 28 U.S.C. § 1441." *Plumbing Indus. Bd. v. E.W. Howell Co.*, 126 F.3d 61, 66 (2d Cir. 1997). Complete preemption prevents plaintiffs from "deny[ing] a defendant access to federal court if the actual nature of the complaint is federal, by artfully pleading a complaint" as including solely state law claims. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488 (7th Cir. 1996) (internal citation and punctuation omitted). We turn first to consider the complete preemption doctrine and then apply it to the circumstances of the case at bar.

**B. Complete Preemption and ERISA**

Complete preemption with respect to ERISA, and consequently "arising under" subject matter jurisdiction after removal from state court, has two prerequisites. "[A] state-law cause of action arises under federal law within the meaning of 28 U.S.C. § 1331, and is removable under 28 U.S.C. § 1441, if (1) the cause of action is based on a state law that is preempted by ERISA [so-called 'conflict' or 'substantive' preemption], and (2) the cause of action is 'within the scope of the civil enforcement provisions' of ERISA § 502(a), 29 U.S.C. § 1132(a)." *Romney v. Lin*, 94 F.3d 74, 78 (2d Cir. 1996) ("*Romney I*") (internal citation omitted), *reh'g denied*, 105 F.3d 806 (2d Cir.) ("*Romney II*"), *cert. denied.*, 522 U.S. 906 (1997); *accord Marcella v.*

*Capital Dist. Physicians' Health Plan, Inc.*, 293 F.3d 42, 46 (2d Cir. 2002).

*1. "Conflict" Preemption.* To satisfy the first part of the test for complete preemption, state law claims must be subject to "conflict" (or "substantive") preemption by ERISA.[7] Section 514(a) of ERISA provides that ERISA "supersede[s] any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in section 1003(a) of this title," with exceptions not relevant here. 29 U.S.C. § 1144(a) (emphasis added); *cf. id.* § 1002(1) (defining "employee welfare benefit plan" to include "any plan, fund, or program . . . established or maintained by an employer or by an employee organization . . . for the purpose of providing for its participants or their beneficiaries . . . medical, surgical, or hospital care or benefits"). "[A] state law relates to an ERISA plan 'if it has a connection with or reference to such a plan.'" *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)).

Glossing the "reference to" language of *Shaw*, the Supreme Court has explained that "[w]here a State's law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation . . . that 'reference' will result in pre-emption." *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr. N.A.*, 519 U.S. 316, 325 (1997) (internal citations omitted). We find no such reference here. Because the state laws invoked by Ms. Cicio, such as that respecting medical malpractice doctrine, act neither immediately nor exclusively

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[7] "Conflict" preemption arises when federal law's constitutionally mandated supremacy over state law requires that federal law displace conflicting state law as a rule of decision. *See Darcangelo v. Verizon Communications, Inc.*, 292 F.3d 181, 186-87 (4th Cir. 2002).

on ERISA plans and because such plans are not "essential to" the laws' operation, we need consider this question no further.

But a state law is also conflict preempted if it has a "connection with" an ERISA plan. *Egelhoff*, 532 U.S. at 147. The requisite connection exists if a law "mandates employee benefit structures or their administration or provides alternative enforcement mechanisms [to ERISA]." *Plumbing Indus. Bd.*, 126 F.3d at 67 (quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995); internal punctuation omitted); *accord HMI Mech. Sys., Inc. v. McGowan*, 266 F.3d 142, 149 (2d Cir. 2001). In this analysis, a court "look[s] both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive as well as to the nature of the effect of the state law on ERISA plans." *Dillingham Constr.*, 519 U.S. at 325 (internal citations and punctuation omitted). Complete preemption in the case at hand, if it exists, must therefore rest on the "connection with" theory.

*2. "Within the scope of" the civil enforcement provisions of ERISA.* Conflict preemption "alone is insufficient to support removal jurisdiction." *Romney I*, 94 F.3d at 78. As noted above, a state law action preempted by ERISA establishes "arising under" jurisdiction only if, under the second part of the complete preemption test, it is *also* a "cause[ ] of action within the scope of the civil enforcement provisions of [ERISA] § 502(a)." *Taylor*, 481 U.S. at 66 (emphasis added); *accord Plumbing Indus. Bd.*, 126 F.3d at 69; *Romney II*, 105 F.3d at 812-13.

Section 502(a)(1)(B) of ERISA provides for actions "to recover benefits due . . . under the terms of [a] plan, to enforce . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Congress thereby created "a comprehensive civil enforcement scheme that represents a

careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). "In enacting §§ 502(a) and 514(a), Congress sought to eliminate alternative state law remedies for benefit plan participants and beneficiaries, relegating such persons to . . . six well-integrated remedies . . . ." *Plumbing Indus. Bd.*, 126 F.3d at 68; *see also Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985) (describing ERISA's "interlocking, interrelated, and interdependent remedial scheme").

The second component of the complete preemption test is met if state law causes of action that are pleaded seek to vindicate rights already protected by § 502(a). These claims are then recharacterized as federal in nature and serve as a basis for "arising under" subject matter jurisdiction. A cause of action is therefore "within the scope of" § 502(a) "only if . . . [it] is properly characterized as seeking 'to recover benefits due to [the plaintiff] under the terms of [the] plan, to enforce his [or her] rights under the terms of the plan, or to clarify his [or her] rights to future benefits under the terms of the plan.'" *Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269, 272 (2d Cir. 1994) (quoting 29 U.S.C. § 1132(a)(1)(B)). But "[a] suit need not be a cognizable, winning claim under § 502(a) in order to fall 'within the scope' of the provision for purposes of the jurisdiction analysis." *Plumbing Indus. Bd.*, 126 F.3d at 69. Any "state cause of action that acts as an alternative means of vindicating the rights protected by § 502(a) is 'within the scope' of the section even if the suit is directed against a defendant not liable under ERISA." *Id.* Jurisdiction exists, then, even over *unsuccessful* attempts to circumvent § 502(a).

With these two prerequisites of complete preemption in mind, we turn to consider whether there is complete preemption of the plaintiff's timeliness and misrepresentation claims so as to permit their removal.

### C. Removal Jurisdiction over the Timeliness and Misrepresentation Claims

*1. The Timeliness Claims.* The plaintiff's timeliness claims rest on "the defendants' [alleged] failure to conduct an appeal of their denial of care . . . in a timely fashion . . . ." Compl. ¶ 66. The plaintiff specifically alleges negligence in defendants' failure to respond promptly to Dr. Samuel's January 28, 1998 request. Her claim draws on New York law to the effect that "a determination involving continued or extended health care services, or additional services for an enrollee undergoing a course of continued treatment," must be made and communicated "by telephone and in writing within one business day of receipt of the necessary information." N.Y. Pub. Health Law § 4903(3); *see also* Compl. ¶ 24; Plaintiff-Appellant's Br. at 2. We conclude that such claims are conflict preempted by § 514. We also conclude that the timeliness claims are "within the scope of" § 502(a). Removal jurisdiction therefore properly obtains over them.

First, with regard to conflict preemption, ERISA already mandates that employee benefit plans "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied." 29 U.S.C. § 1133(1). Regulations issued by the Secretary of Labor pursuant to 29 U.S.C. § 1135 "set[ ] forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries." 29 C.F.R. § 2560.503-1(a). A request "to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible . . . and the plan administrator shall notify the claimant . . . within 24 hours after receipt of the claim by the plan . . . ," *id.* § 2560.503-1(f)(2)(ii)(B). Otherwise, a plan administrator must generally act within ninety days, *id.* § 2560.503-1(f)(1).

The New York law that plaintiff attempts to enforce thus has an "effect on the primary administrative functions of benefit plans," *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989), and conflicts with regulations established pursuant to ERISA. By requiring that health benefits plans reply to requests for "additional services for . . . continued treatment" within twenty-four hours, N.Y. Pub. Health Law § 4903(3), New York law establishes a different rule from ERISA's, which requires action within the same time-frame only if a claim involves continuing "urgent care," 29 C.F.R. § 2560.503-1(f)(2)(ii)(B).[8]

The second part of the test for complete preemption—that the cause of action be "within the scope of" § 502(a)—is also satisfied because the plaintiff's timeliness claims are "an alternative mechanism . . . for enforcing the rights protected by ERISA." *Plumbing Indus. Bd.*, 126 F.3d at 68. Under § 502(a)(1), a participant or beneficiary of a plan may file suit "to enforce his [or her] rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(A). And an enrollee in an

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[8] In reaching this conclusion, we tread a well-worn path. "[C]ommon law causes of action . . . based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for pre-emption under § 514(a)." *Pilot Life*, 481 U.S. at 48. In light of *Pilot Life*'s conclusion, circuit courts have uniformly concluded that tort claims of negligence based solely on delay in processing are preempted. *See, e.g.*, *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 273 (3d Cir. 2001) (preempting "a claim that the HMO or plan administrator delayed"); *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1007-08 (9th Cir. 1998) (rejecting a state law wrongful death suit based on improper processing of a claim), *cert. denied*, 528 U.S. 870 (1999); *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270, 1273-74 (10th Cir.) (preempting a claim of negligence in approving treatment), *cert. denied*, 519 U.S. 816 (1996); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131-32 (9th Cir. 1993) (preempting a wrongful death action based on failure to approve treatment in a timely fashion), *cert. denied*, 511 U.S. 1052 (1994).

ERISA-governed plan has a right to timely determinations. *See* 29 C.F.R. § 2560.503-1(f)(2)(ii)(B). The Cicios could thus have brought suit for injunctive relief under § 502(a)(1)(B) in February or March 1998 to seek to obtain authorization for the double stem cell transplant. An attempt to vindicate the same interest through a state law mechanism is an action "within the scope of" § 502(a), *Taylor*, 481 U.S. at 66.

The timeliness claims therefore meet the second prerequisite to complete preemption. Removal jurisdiction with respect to them is thus established.

*2. The Misrepresentation Claims.* The plaintiff also alleges that Vytra "intentionally withheld information from its customers regarding defendants' intention to interpret its policies in a manner inconsistent with, and contrary to, its own understanding of the policies' provisions" before the Cicios accepted coverage, and upon execution of the Plan, "adopted inconsistent and incorrect interpretations of the term 'medical necessity' and other terms contained in the Policy." Compl. ¶¶ 83, 90. These claims, too, are subject to complete preemption.

First, "ERISA preempts state common law claims of fraudulent or negligent misrepresentation when the false representations concern the existence or extent of benefits under an employee benefit plan." *Griggs v. E.I. Dupont de Nemours & Co.*, 237 F.3d 371, 378 (4th Cir. 2001). In other words, the cause of action that the plaintiff's misrepresentation claims rely upon is conflict preempted.

Second, the misrepresentation claims rest on the allegation that Vytra had an obligation under the terms of the plan to provide benefits that it failed to provide. The claims thus seek to vindicate rights accruing under the plan. But ERISA § 502(a)(1)(B) allows recovery of "benefits due . . . under the terms of [a] plan." 29 U.S.C. § 1132(a)(1)(B). And we have previously rejected similar state law claims—to the

effect that a plan administrator misrepresented the availability of benefits under a plan—as "attempt[s] to supplement the plan's express provisions and secure an additional benefit." *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 10 (2d Cir. 1992); *see also Carlo v. Reed Rolled Thread Die Co.*, 49 F.3d 790, 793-94 (1st Cir. 1995) (concluding that a negligent misrepresentation claim was preempted because it sought allegedly promised plan benefits as damages).[9] As an alternative means of enforcing plan-related rights created by ERISA, the misrepresentation claims are then also "within the scope of § 502(a)," *Taylor*, 481 U.S. at 66.

Both prerequisites for complete preemption are satisfied, so removal jurisdiction was properly exercised by the district court over the misrepresentation claims too.

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[9] The complaint might be read to reference representations made before the Cicios entered the contract, and some courts have concluded that a misrepresentation claim based on actions before a contract has been signed are not preempted. *See, e.g., Neuma, Inc. v. AMP, Inc.*, 259 F.3d 864, 880-81 (7th Cir. 2001). But the misrepresentations in *Neuma* concerned the value of the benefits package as a whole, not whether the package contained specific benefits. *See id.* at 869. The misrepresentation claim in *Neuma*, unlike those made by Ms. Cicio, did not require an interpretation of the terms of the plan.

In other cases concerning alleged misrepresentations made before a plan contract commenced, courts have found state law claims preempted because the claims seek, in essence, to vindicate contractual rights. *See Hall v. Blue Cross/Blue Shield of Ala.*, 134 F.3d 1063, 1065 (11th Cir.) (preempting a state law claim based on alleged fraudulent marketing because "no court will be able to determine whether [the plaintiff] has been fraudulently induced without resorting to the written policy") (emphasis in original omitted), *reh'g en banc denied*, 158 F.3d 590 (11th Cir. 1998); *Degnan v. Publicker Indus., Inc.*, 83 F.3d 27, 30 (1st Cir. 1996) (rejecting as preempted a claim of misrepresentation). The misrepresentation claims in the case at bar are more akin to the latter than those alleged in *Neuma* insofar as they seek to recover benefits allegedly due under the plan.

**D. Supplemental Jurisdiction**

Under 28 U.S.C. § 1367(a), a district court has "supplemental jurisdiction over all other claims that are so related to claims in the action within such original jurisdiction that they form part of the same case or controversy" once original jurisdiction is established. *Id.* A state law claim forms part of the same controversy if it and the federal claim "derive from a common nucleus of operative fact." *City of Chicago v. Int'l Coll. of Surgeons*, 522 U.S. 156, 165 (1997) (quoting *United Mine Workers of Am. v. Gibbs*, 383 U.S. 715, 725 (1966)); *see also Gibbs*, 383 U.S. at 725 ("[I]f, considered without regard to their federal or state character, a plaintiff's claims are such that he would ordinarily be expected to try them all in one judicial proceeding, then, assuming substantiality of the federal issues, there is *power* in federal courts to hear the whole.") (emphasis in original).

All Ms. Cicio's claims "derive from a common nucleus of operative fact," *Gibbs*, 383 U.S. at 725, to wit, the denial by Dr. Spears of authorization for a double stem cell transplant. All relevant events allegedly transpired between January 28, 1998, when Dr. Samuel first requested the double stem cell transplant, and May 11, 1998, when Mr. Cicio died. The plaintiff "would ordinarily be expected to try [ ] all [of her claims] in one judicial proceeding." *Id.* Subject matter jurisdiction thus exists over Ms. Cicio's malpractice claims under 28 U.S.C. § 1367(a), irrespective of whether, standing alone, they are removable.

**IV. Dismissal of the Timeliness and Misrepresentation Claims**

After determining that the entire complaint was properly removable so that subject matter jurisdiction obtained, the magistrate judge and district court determined that the defendants' Rule 12(b)(6) motion should be granted because the plaintiff's asserted causes of action were all preempted

by ERISA. *Cicio*, 208 F. Supp. 2d at 293, 302. The preceding jurisdictional analysis, in addition to establishing that removal was appropriate, demonstrates that dismissal of the timeliness and misrepresentation claims was appropriate.

As discussed above, the timeliness and misrepresentation claims brought under New York state law are both "alternative mechanism[s] . . . for enforcing the rights protected by ERISA." *Plumbing Indus. Bd.*, 126 F.3d at 68. For that reason, they are conflict preempted by ERISA because they attempt to regulate in an area where Congress, through ERISA, has swept away all state regulation. In the preemptive shadow of ERISA, no state cause of action can lie, *cf. id.* at 68-70 (dismissing state law claims for similar reasons), and therefore these claims were rightly dismissed. All that remains for our consideration, then, are the medical malpractice claims.

## V. Preemption of Medical Malpractice Claims

The question whether a state law medical malpractice claim brought with respect to a medical decision made in the course of prospective utilization review by a managed care organization or health insurer is preempted under ERISA § 514, and therefore beyond the reach of state tort law, is one of first impression in this Circuit. We conclude, largely on the basis of recent Supreme Court decisions, that such a state law claim is not preempted.

### A. The Practice of Utilization Review

The plaintiff's medical malpractice claims are based on Dr. Spears's denial of coverage for a double stem cell transplant for Mr. Cicio. Letter from Brent W. Spears to Edward T. Samuel dated February 23, 1998, at 1. Dr. Spears's decision occurred in the course of Dr. Samuel's attempt to obtain authorization for the double stem cell transplant from Vytra. Compl. ¶¶ 15, 19-21. The complaint then details a process of utilization review, and it is the

nature of this procedure, and its relation to ERISA, upon which we now focus.

Utilization review usually involves "prospective review by a third party of the necessity of medical care." *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1326 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992); *see also Pegram*, 530 U.S. at 219.[10] "[T]he typical prospective review system requires some form of pre-admission certification by a third party," *Corcoran*, 965 F.2d at 1327, such as Vytra's Medical Director, Dr. Spears. "Although prospective utilization review involves no traditional face-to-face clinical encounter, it is still quasi-medical in nature. It necessarily involves evaluation of data collected in such an encounter." *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1, 5 n.5 (1st Cir. 1999); *see also Corcoran*, 965 F.2d at 1331 (characterizing utilization review as a medical decision); Note, Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1318 (1994) ("Cost-containment programs . . . redistribute what we normally consider 'medical authority' to nontraditional actors."). Prospective utilization review blurs boundaries between the traditionally "distinct sphere of professional dominance and autonomy" of the medical profession on the one hand, Paul Starr, *The Social Transformation of American Medicine* 27 (1982), and the managerial domain on the other. As such, it represents a development apparently unforeseen

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[10] The term "utilization review" is also applied in some federal statutes. For example, the determination by a hospital or skilled nursing care facility that an admission or continued stay is or is not medically necessary in connection with the availability of Medicare coverage is made by a "utilization review committee" established under the dictates of the Social Security law. *See Kraemer v. Heckler*, 737 F.2d 214, 214-16 (2d Cir. 1984) (describing Medicare procedures under 42 U.S.C. § 1395x and 42 C.F.R. § 405.1035).

at the time of ERISA's enactment. *See* Jeffrey E. Shuren, *Legal Accountability for Utilization Review in ERISA Health Plans*, 77 N.C. L. REV. 731, 733 (1999).

Moreover, as other courts have noted, "a system of prospective decisionmaking influences the beneficiary's choice among treatment options to a far greater degree than does the theoretical risk of disallowance of a claim facing a beneficiary in a retrospective system." *Corcoran*, 965 F.2d at 1332; *accord Danca*, 185 F.3d at 5 n.5. And, "[i]n many instances, a denial of coverage results in the patient forgoing the procedure altogether." J. Scott Andresen, *Is Utilization Review the Practice of Medicine?*, 19 J. LEGAL MED. 431, 432 (1998). Thus, decisions with a medical component—i.e., involving the exercise of medical judgment in relation to a particular patient's symptoms—are made in the course of utilization review by staff who are independent of and separate from the locus of traditional medical decision-making authority. These medical decisions have possibly dispositive consequences for the course of treatment that a patient ultimately follows.

**B. ERISA's Preemptive Scope**

The Supreme Court, in its early pronouncements on ERISA preemption, suggested that the sweeping reference to "any and all State laws [that] . . . relate" to benefits plans in ERISA's preemption provision, 29 U.S.C. § 1144(a), entailed an expansive preemptive effect that corresponded to the provision's broad wording. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990); *Pilot Life*, 481 U.S. at 47, *Russell*, 473 U.S. at 146-47; *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). Since then, however, the Court has "temper[ed] the assumption that the ordinary meaning [of § 514] . . . accurately expresses the legislative purpose . . . with the qualification that the historic police powers of the States were not meant to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S.

355 (2002) (internal citations and punctuation omitted). In recent discussions of ERISA preemption, it has even been hinted that "the criteria set forth in [early cases like *Shaw* and its progeny] have in effect been abandoned." *Dillingham Constr.*, 519 U.S. at 335 (Scalia, J., concurring).

Specifically, the Supreme Court has rejected the notion that any finely filigreed connection between ERISA and a state law establish ERISA preemption, and, instead, has held that a court must begin with the presumption that "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestations of congressional purpose." *Pegram*, 530 U.S. at 237; *accord Rush Prudential*, 122 S. Ct. at 2171; *see also De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813-14 (1997) (applying a presumption that "Congress does not intend to supplant state law"; internal citation omitted); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654 (1995) (same). Moving beyond presumptions, the Supreme Court has also, in its own words, thrown "cold water" on the idea that state regulation of health and safety is necessarily preempted even when it overlaps with rights protected by ERISA. *Pegram*, 530 U.S. at 237 (citing *Travelers*, 514 U.S. at 654-55).

In deciding the preemption question, it is also noteworthy that ERISA's "repeatedly emphasized purpose [is] to protect *contractually* defined benefits." *Russell*, 473 U.S. at 148 (emphasis added); *accord Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (reiterating the focus on "contractually defined benefits") (internal citation omitted); *Russell*, 473 U.S. at 147 (noting the centrality of "contractually authorized benefits"). Indeed, one of ERISA's stated goals involves increasing "the likelihood that full benefits will be paid to participants and beneficiaries of [covered] plans." 29 U.S.C. § 1001b(b)(1). State medical malpractice law, by contrast, even if implicated by the execution of a benefits decision, involves the application of

duties of conduct that are defined independent of ERISA plans.[11] As such, it is not among the "rights and expectations brought into being by [ERISA]," *Ingersoll-Rand*, 498 U.S. at 137 (internal citation omitted), that § 502(a) is designed to protect.

We must therefore ask whether the plaintiff's medical malpractice causes of action "relate to" the benefits plan administered by Vytra, keeping in mind both the Supreme Court's warning that state law regulation of medical practice is not to be lightly disturbed, and the observation that ERISA's primary focus is the protection of contractual rights defined by benefits plans.

### C. The Preemption of Medical Malpractice Claims Against Utilization Review Decisions

*1. Pegram v. Herdrich.* At first blush, the defendants' contention that Dr. Spears's decision concerned a benefits determination about what medical treatments Mr. Cicio could receive pursuant to the plan, a decision that can only be challenged in a § 502(a)(1)(B) action, has considerable force. Other courts addressing similar facts have concluded that malpractice claims based on utilization review decisions are indeed preempted by § 514. They have reasoned, first, that utilization review involves "medical decisions as part and parcel of [a plan's] mandate to decide what benefits are available," and then held that, as benefits decisions, utilization review decisions can be challenged only in a § 502(a)(1)(B) action. *Corcoran*, 965 F.2d at 1332; *see also Jass*, 88 F.3d at 1489-90 (holding preempted a negligence action against a utilization review agent); *Tolton v. Am.*

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[11] Even if, absent a benefits contract, no medical care would in fact have been furnished, so that the medical judgment in one sense is a "benefit" and a direct consequence of the exercise of a contractual right, the state law obligation to provide care of a given level of quality when providing care is nonetheless distinct from the contract.

*Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995) (rejecting as preempted a malpractice claim against a utilization review decision because the defendants "were determining what benefits were available . . . under the plan"); *Brandon v. Aetna Servs., Inc.*, 46 F. Supp. 2d 110, 113-14 (D.Conn. 1999) (similar); *cf. Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 534 (5th Cir.) ("ERISA preempts malpractice suits against doctors making coverage decisions in the administration of a plan . . . ."), *reh'g in banc denied*, 220 F.3d 641 (5th Cir. 2000), *vacated and remanded on other grounds sub nom. Montemayor v. Corporate Health Ins.*, 536 U.S. 935 (2002); *Rice v. Panchal*, 65 F.3d 637, 644 (7th Cir. 1995) (holding that "where the state law has the effect of creating a qualitative standard . . . by which the performance of the contract is evaluated, then that state law is completely preempted"). These cases rest on the proposition that a decision cannot be the basis of a malpractice claim even if it involves the exercise of medical judgment if at the same time it has a benefits determination component. According to these cases, the performance of contractual interpretation in order to determine benefits triggers preemption without regard to the medical content of a decision.

But *Corcoran*, *Jass*, and *Tolton* were decided before the Supreme Court's recent retrenchment of ERISA preemption's margins, and before the Court, in its unanimous decision in *Pegram v. Herdrich*, addressed (albeit in dicta) medical malpractice actions against those engaged in medical decision making.

*Pegram* concerned a defendant physician who "decided (wrongly, as it turned out) that [the plaintiff's] condition did not warrant immediate action; the consequence of that medical determination was that [the defendant HMO] would not cover immediate care, whereas it would have done so if

[the defendant physician] had made the proper diagnosis and judgment to treat."[12] 530 U.S. at 229. *Pegram* addressed only whether an HMO had, by its method of sharing profits with doctors, breached its fiduciary duty to members, disclaiming any suggestion that it was addressing the interaction between § 502 and state law claims. 530 U.S. at 229 n.9. *Pegram* is nonetheless relevant to the case at hand because of the reasoning upon which the Court's conclusion was based. The Court decided that no fiduciary breach action could be brought under ERISA because, in part, such an action would be a "mere replication of state malpractice actions with HMO defendants," *id.* at 236. The creation of a fiduciary breach action through "the formulaic addition of an allegation of financial incentive [to a malpractice claim] would do nothing but bring the same claim into a federal court under federal-question jurisdiction." *Id.* at 235. We thus infer that the continued availability of some state law malpractice actions based on at least some varieties of utilization review decisions was a predicate of the Court's holding.

But the *Pegram* opinion has further ramifications for our analysis because of its detailed description and analysis of decision-making in the context of health care provision. The Court categorized the defendant Dr. Pegram's act as a "mixed eligibility and treatment" decision, i.e., an "eligibility decision [that] cannot be untangled from physicians' judgments about reasonable medical treatment." *Id.* at 229. The *Pegram* Court then explained:

What we will call pure "eligibility decisions" turn on the

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[12] A patient, the plaintiff Cynthia Herdrich, had experienced pain in her groin, and submitted to an examination by Dr. Pegram. 530 U.S. at 215. Despite discovering a significant inflamed mass in Herdrich's abdomen, Dr. Pegram did not order an immediate diagnostic ultrasound. *Id.* Before Herdrich was to have received the ultrasound, her appendix ruptured. *Id.*

> plan's coverage of a particular condition or medical procedure for its treatment. "Treatment decisions," by contrast, are choices about how to go about diagnosing and treating a patient's condition: *given a patient's constellation of symptoms, what is the appropriate medical response?*
>
> These decisions are often practically inextricable from one another .... This is so *not merely because*, under a scheme like [the benefits plan in *Pegram*], *treatment and eligibility decisions are made by the same person, the treating physician. It is so because a great many and possibly most coverage questions are not simple yes-or-no questions*, like whether appendicitis is a covered condition (when there is no dispute that a patient has appendicitis), or whether acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged). The more common coverage question is a when-and-how question. Although coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians still must decide what to do in particular cases. The issue may be, say, whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement that conditions the HMO's obligation to provide *or pay for* that particular procedure at that time in that case.

*Id.* at 228-29 (citations omitted; emphasis added).

*Pegram* thus suggests that some decisions involve interpretation of a benefits contract, eligibility decisions, and some involve application of medical judgment to a particular patient's condition, treatment decisions. And these two categories overlap. The resulting third category, described in *Pegram*, of "mixed eligibility and treatment decisions," *id.* at 229, is not limited to decisions made by treating physicians, such as Dr. Pegram, who both assess which benefits a plan

provides and make treatment decisions. A decision about who will "pay for" a procedure, even when this decision is not made by a "treating physician," is also a "mixed eligibility and treatment decision" if it involves answering the question: "given a patient's constellation of symptoms, what is the [most] appropriate medical response?" *Id.* at 228-29. In other words, even if a physician does not directly control, direct, or influence a plaintiff's treatment, and even if the sole consequence of a physician's decision is reimbursement or its denial, that decision may nonetheless be a mixed eligibility and treatment decision like Dr. Pegram's. *Id.*

*Pegram* thus alters the framework used in *Corcoran*, *Jass*, and *Tolton*, in which a decision must be about either "treatment" or "eligibility," and in which any element of benefits determination suffices to make a decision an "eligibility" decision that may only be challenged in a § 502(a) action. The *Pegram* court's analysis suggests instead that courts should recognize that "[i]n recent years, the medical profession's monopoly on the authority to define appropriate health care outcomes for society has been severely eroded." Frankel, *supra*, at 1320; *see also* Starr, *supra*, at 27 (describing threats to physician autonomy). The "separation between professional providers and lay financiers," which *Corcoran*, *Jass*, and *Tolton* presumed, "no longer exists." Frankel, *supra*, at 1320; *cf.* Starr, *supra*, at 447 (observing "increasing corporate [as opposed to professional] influence over the rules and standards of medical care"); Shuren, *supra*, at 748 (noting that utilization review agents "interpos[e] themselves into medical decisionmaking"). Decisions now regularly made by third-party payers, such as "whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement" in a health benefits contract, "cannot be untangled from physicians' judgments about reasonable medical treatment," *Pegram*, 530 U.S. at

229. And such coverage decisions based on medical determinations often have an outcome-determinative effect. *See Corcoran*, 965 F.2d at 1332; *Danca*, 185 F.3d at 5 n.5; Andresen, *supra*, at 432. Among such decisions, noted the *Pegram* Court, are ones concerning "the experimental character of a proposed course of treatment." *Pegram*, 530 U.S. at 229-30.

The defendants' decision in this case, in the current procedural posture of this appeal, must be treated as a mixed decision because it allegedly involved both an exercise of medical judgment and an element of contract interpretation.

*2. Applying Pegram's Tripartite Analysis to ERISA Preemption.* We conclude that a state law malpractice action, if based on a "mixed eligibility and treatment decision," is not subject to ERISA preemption when that state law cause of action challenges an allegedly flawed medical judgment as applied to a particular patient's symptoms. We reach this conclusion by applying the presumptions previously discussed, our understanding of congressional intent in enacting ERISA, and the analytic framework established in *Pegram*.

At the threshold, we decline to adopt the categorical distinction between "quality of care" decisions and "benefits administration" questions applied by other courts in the ERISA preemption context, *Pryzbowski*, 245 F.3d at 279, and by the district court in the case at bar, *Cicio*, 208 F. Supp. 2d at 293. To frame the issue in that fashion is to ignore the nature of "countless medical administrative decisions every day" in which "the eligibility decision and the treatment decision [are] inextricably mixed." *Pegram*,

530 U.S. at 229. *Pegram* teaches that this dichotomy is no longer tenable.[13]

Further, *Pegram* demonstrates that the mere presence of an administrative component in a health care decision no longer has determinative significance for purposes of preemption analysis when the decision also has a medical component. In its brief discussion of the "puzzling issue of preemption," the *Pegram* Court rejected one of the plaintiff's arguments as "a prescription for preemption of state malpractice law." *Id.* at 236. The Court said, as we have noted, that previous cases had already thrown "cold water on the preemption theory [with regard to state law malpractice claims]." *Id.* at 237. The Court's analysis strongly suggests, without holding, that the plaintiff's malpractice action against Dr. Pegram would not be preempted even though Dr. Pegram simultaneously made a contractual interpretation concerning Herdrich's eligibility for given benefits, and that a defendant can no longer simply point to the overlay of medical decision-making on contractual claims and ask the court to conclude that, because ERISA preempts the contract claims, it also preempts all state tort-law claims based on the same decision.

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[13] We think that Judge Calabresi, in his partial dissent, fails sufficiently to take into account the shift in the legal and medical landscape clearly marked by the unanimous *Pegram* decision. The question is no longer an either/or between eligibility and treatment—whether, as Judge Calabresi phrases it, the plaintiff's action is "essentially [a suit] against an insurance provider for negligently failing to give the coverage contracted for, or . . . against a medical care provider for negligent failure to treat." Dissent at 108. Frequently, health care decisions (including perhaps Dr. Spear's)—so-called "mixed eligibility and treatment decisions," *Pegram*, 530 U.S. at 229—now contain elements of both. And the medical element can give rise to "state malpractice actions with HMO defendants," *id.* at 236, if state law so provides, even if the defendants were simultaneously "determining the scope and coverage of an ERISA-plan contract," dissent at 109.

As we have explained, nothing in ERISA suggests that Congress intended any displacement of "the quintessentially state-law standards of reasonable medical care" as applied to the medical component of a mixed decision. *Rush Prudential*, 122 S. Ct. at 2171. And ERISA requires that we distinguish between "contractually defined benefits," *Russell*, 473 U.S. at 148, and those rights that state law delimits independent of benefits plans, such as medical quality standards, which hinge instead on statutory and common law development of malpractice law unique to each state.

Finally, we note our skepticism of a line of reasoning that would draw from "a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans," *Shaw*, 463 U.S. at 90, the elimination of protective standards of professional conduct. We see no reason then to bar as preempted state law malpractice actions that rest on the application of standards for medical decision-making—which are established by states independent of and prior to health benefits contracts—to "a patient's constellation of symptoms," *Pegram*, 530 U.S. at 228. *Accord Isaac v. Seabury & Smith, Inc.*, 2002 WL 1461710, *6-*8, 2002 U.S. Dist. LEXIS 12413, *19-*28 (S.D.Ind. July 5, 2002) (finding no complete preemption of a medical malpractice action based upon a utilization review decision).

Focusing on mixed eligibility and treatment decisions, then, we conclude that § 514 preemption does not obtain with regard to those claims predicated on the violation of a state tort law by a failure to meet a state-law defined standard of care in diagnosing or recommending treatment of a plaintiff "patient's constellation of symptoms," *Pegram*, 530 U.S. at 228.

*3. The Distinction Between Treating Physicians and Utilization Review Agents.* The district court appeared to distinguish between a tort action based on a pre-certification

decision, such as Dr. Spears's decision here, and one based on a contemporaneous treatment decision, such as Dr. Pegram's. *See Cicio*, 208 F. Supp. 2d at 293 (distinguishing between Dr. Pegram's decision and an anterior decision about "eligibility for coverage"). In support of this distinction, it might be argued that, in the pre-certification context, the treatment analysis precedes the contract interpretation question such that adjudication of a tort action *necessarily* involves an interpretation of the ERISA contract, which in turn triggers preemption. And it might be further argued that in contemporaneous treatment questions, the contract interpretation question does not play the same intervening role.

But we are not convinced such a distinction can in fact be drawn. *Pegram*, as noted, did not distinguish between the decisions of a treating physician empowered to interpret a benefits contract, and medical administrative decisions executed prior to the delivery of care. Its category of mixed eligibility and treatment decisions consisted of "when-and-how question[s]," including, critically, the question whether "a decision to proceed with [a procedure] would meet the medical necessity requirement that conditions the HMO's obligation to provide *or pay for* that particular procedure." *Pegram*, 530 U.S. at 228-29 (emphasis added). Even when making decisions about whether to pay for particular procedures, "physicians still must decide what to do in particular cases" on the basis of medical assessments. *Id.* at 229.

And, "[i]n practical terms, . . . eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment," or, at least, the untangling will in many instances be no easy task. *Id.* For instance, some managed care organizations require that utilization review agents "negotiate with the treating physician to achieve conformity" in levels of care provided. Shuren, *supra*, at 746-47. That sort of negotiation is reflected in the correspondence

between Drs. Spears and Samuel. While Dr. Samuel initiated negotiations with a detailed description of Mr. Cicio's status, Dr. Spears parried with an assertion of the requested treatment's experimental nature. Dr. Samuel then supplemented his argument with support from the medical literature. In response, Dr. Spears apparently made a patient-specific prescription of appropriate treatment by denying one treatment and authorizing another that Dr. Samuel had not requested. At least on the basis of the material on which we review the grant of the Rule 12(b)(6) motion by the district court, we cannot identify distinct moments at which treatment decisions as distinct from eligibility decisions were made in the course of this negotiation, let alone the sequence of such decisions.

In the *Pegram* context of contemporaneous treatment decisions, too, how to distill the moment of the eligibility determination from the facts is far from obvious. Examining the Supreme Court's description of Dr. Pegram's behavior, we cannot determine whether she (1) thought first about how soon Herdrich needed an ultrasound and then considered whether the plan comprised ultrasound tests in a given medical facility, or (2) considered first which benefits were available, and only then analyzed which one was medically warranted within that constrained range. *See Pegram*, 530 U.S. at 215. In other words, it is difficult, at best, to determine whether her violation of the standard of medical care was apart from and independent of a determination of benefits, or whether the benefits determination preceded and controlled the medical determination.

In sum, it would likely often be difficult to delve into physicians' minds to examine their decisions, which are frequently executed in very brief time-periods and under tremendous pressures, to determine what part of them is medical and what part is administrative. Nor do we think it likely that significant contract interpretation issues will arise in an ensuing tort action. Assuming *arguendo* that Ms. Cicio

were to establish that Dr. Spears's decision violated a state law duty of professional care, we are hard pressed to see how the defendants could successfully contend—as a defense to the *tort* action—that the *contract* permitted them to violate a state law duty standard of care.[14]

**D. Caveats**

We underscore the fact that this case comes before us on appeal from the grant of a Rule 12(b)(6) motion to dismiss. We therefore hold only that a set of facts consistent with the allegations contained in the complaint would permit the granting of relief-oddly, in this case, remand to state court for a determination, *inter alia*, of whether the complaint states a cause of action under the law of New York. If Dr. Spears's actions that are the subject of the complaint indeed constituted a medical decision or a mixed medical and eligibility decision, then Ms. Cicio's remaining medical malpractice claims should not be dismissed, but remanded to state court for resolution. *See Giordano v. City of N.Y.*, 274 F.3d 740, 754-55 (2d Cir. 2001). It may nonetheless be that, as a matter of fact, Dr. Spears's decision was purely one concerning eligibility, *i.e.*, a determination that, without regard to Mr. Cicio's "constellation of symptoms" but in the abstract, double cell stem transplants were experimental as treatment for multiple myeloma. In that case, the claims would be completely preempted by ERISA and therefore subject to dismissal. We therefore do not rule out the possibility that the defendants can demonstrate, *as a matter*

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[14] Certainly, it would be a different matter if the complaint alleged only that the health benefits plan did not cover a given procedure without regard to what symptoms a patient presented. In that case, the defendants would in fact be contending that they made no medical decision that could be subject to state law standards for medical care, but rather only interpreted the contract. In such cases, a court would have to make a threshold determination, as we have done in the case at bar, as to whether a medical decision made by the defendants has been alleged.

*of fact*, that dismissal of the complaint is warranted. We leave it to the district court to determine what proceedings, if any, would be appropriate to that end.

Finally, we reiterate that we do not decide under what circumstances, if any, the decisions made by Vytra or Dr. Spears, or utilization review decisions generally, may when negligently made be actionable under New York law. Perhaps they never are. Unless the district court determines that Dr. Spears was in fact making pure eligibility decisions with respect to Mr. Cicio's health care and dismisses the claim on that ground, that will be a question for the New York courts to decide upon remand.

## CONCLUSION

We affirm the district court's disposition of the timeliness and misrepresentation claims, but vacate its resolution of the medical malpractice claims and remand for further proceedings consistent with this opinion.

CALABRESI, Circuit Judge, dissenting in part.

How can one object to the result reached by the court in this case? Taking its inspiration from some words in *Pegram v. Herdrich*, 530 U.S. 211 (2000), the majority elegantly skirts the boundary of ERISA preemption to avoid an outrageous outcome. Appellants allege that Mr. Cicio might well have survived, had not the plan administrator negligently denied coverage for Mr. Cicio's treatment. Under the circumstances, it seems no more than just to allow his widow's suit for malpractice to proceed in state court, as the majority does. And I certainly share in the majority's "skepticism of a line of reasoning that would draw from a 'comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans,' the elimination of protective standards of professional conduct." *Ante*, at 104 (internal citation removed).

Yet in the end I cannot reconcile the majority's holding with the Supreme Court's precedents and with the structure of ERISA itself, given those precedents. Nor do I believe that the majority opinion somehow "fixes" the problem with the ERISA caselaw. The conclusion that my colleagues have reached today is a band-aid on a gaping wound. It may provide justice to Mrs. Cicio, and I'm glad for that, but the injury that the courts have done to ERISA will not be healed until the Supreme Court reconsiders the existence of consequential damages under the statute, or Congress revisits the law to the same end.

I.

The country's leading ERISA scholar, John Langbein, has demonstrated that ERISA § 502(a), the civil remedies section, closely tracks the traditional remedies of trust law. *See* John H. Langbein, What ERISA Means by "Equitable": The Supreme Court's Trail of Error in *Russell*, *Mertens*, and *Great West*, Yale Law & Economics Research Paper No. 269 (Jan. 2003), *available at* www.ssrn.com. Under traditional precepts, an aggrieved trust beneficiary "may recover (1) for loss incurred, (2) for any profits that the trustee made in breach of trust, and (3) for any gains that would have accrued but for the breach," i.e., for consequential damages. *Id.* at 29. Trust beneficiaries may not, however, recover punitive damages. *Id.* at 59. By setting into motion the development of a body of federal trust law to govern benefit plan administration, and by preempting state laws that would add (or subtract) to the relief provided by § 502, the drafters of ERISA nicely "balanc[ed] the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

Or so Congress and ERISA beneficiaries fairly could have hoped. What they got instead was the Supreme Court's "Trail of Error," in which the Court lumped consequential and punitive damages into the misleading category of

"extracontractual relief," *see Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985), and disallowed both by dint of an anachronistic (and historically false) law/equity distinction said to be implicit in Congress's provision for "appropriate equitable relief" in § 502(a)(3). *See Mertens v. Hewitt Assocs.*, 508 U.S. 248, 255 (1993); *see generally* Langbein, Trail of Error, at 28-75, and especially 62-73. The upshot is that ERISA, despite its ambition, today generally does not "make whole" plan beneficiaries harmed by plan administrators' misconduct. *See ante* at 95, n.8, and sources there cited.

Not surprisingly, there has developed pressure on ERISA's preemption provisions, so that the states may see to it that plan beneficiaries who under a proper, trust-based reading of § 502(a) would be adequately cared for by ERISA, are otherwise protected ex ante, or compensated ex post, under state law. The Supreme Court's recent holding in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), and its discursion on "mixed" eligibility and treatment decision in *Pegram*, is evidence of that pressure. But the opportunistic attacks on preemption that may result will serve mainly to complicate ERISA and to create anomalous results. Some deserving plaintiffs will be helped out along the way, but many others will obtain no relief, and providers will increasingly have to face that very patchwork of liability risks—differing from state to state—that ERISA's preemptive scheme was meant to avoid.

Because it is not too late for the Supreme Court to retrace its Trail of Error and start over from the beginning,[1] or for

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[1] ERISA is a difficult statute, and the Supreme Court has shown admirable flexibility in its approach to the law. *See, e.g., N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) ("[W]e have to recognize that our prior attempt to construe the phrase 'relate to' [in ERISA's express preemption section] does not give us much help drawing the line here."). The Court's

Congress to wipe the slate clean, I decline to join in Part V of the majority's opinion.

II.

A short dissent is not the place to delve deeply into the mysteries of ERISA preemption law.[2] Suffice it to say that, after a disastrous flirtation with the notion that any cause of action that was in any way connected to an ERISA contract was preempted by ERISA, the law has moved more and more in the direction of barring only those state actions which, if local law were permitted to govern, would expand (or contract) the relief available beyond that provided by § 502(a) of ERISA. *See Cal. Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.*, 519 U.S. 316, 334-36 (1997) (Scalia, *J.*, concurring) (recognizing problems with the Court's early ERISA preemption decisions, and calling for a more open acknowledgment of the evolution that has occurred in the ERISA preemption jurisprudence); *Rush Prudential*, 122 S. Ct. at 2167 ("While independent review under [an Illinois claims-review statute] may well settle the fate of a benefit claim under a particular contract, . . . the relief ultimately available [, i.e., coverage of

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willingness to update its initial gloss on ERISA preemption is cause for hope that the Court may yet revisit its disallowance of consequential damages under § 502(a)(3).

[2] In particular, I do not deem it worthwhile to get into the vagaries of when express preemption under ERISA dictates a result, and when, additionally, complete preemption requires that the case be heard in federal court. It is enough to note that the arguments I make, if valid, require complete preemption in this case. Specifically, permitting this suit to go forward would mean allowing an "alternative enforcement mechanism" to that provided by ERISA's civil remedies section. *See Plumbing Indus. Bd. Local Union No. 1 v. E.W. Howell Co.*, 126 F.3d 61, 67 (2d Cir. 1997), quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans*, 514 U.S. at 658 (1995).

the disputed medical procedure,] would still be what ERISA authorizes in a suit for benefits under [§ 502(a)]."). Even accepting this more limited—and I believe more sensible—scope of preemption, where does that leave Mrs. Cicio's suit? The answer lies in whether the suit, in its essence, is to obtain relief for the violation of rights under the terms of the ERISA plan, in which case the state action is preempted, or whether it is a suit for malpractice against a doctor (or the doctor's employer) as to which the existence of ERISA coverage is only incidental. To put it another way, if ERISA were not there, would this suit essentially be against an insurance provider for negligently failing to give the coverage contracted for, or would the suit be against a medical care provider for negligent failure to treat? Because I think that the current suit is clearly of the first sort, I regretfully conclude that it is barred.

It is, of course, possible that the insurance provider is also the medical care provider. In such cases, in which propriety of treatment and propriety of judgment as to eligibility under an ERISA plan are intertwined, I do not believe that a state-law malpractice suit would be preempted. Such a state-law action cannot be preempted, simply because the *treatment* decision was made by the same person who made the improper decision as to the *scope of coverage* under an ERISA plan. The fact that the medical malpractice and the contract misinterpretation involved the exact same error does not make the state tort action in any way dependent on a finding that the ERISA contract has been breached. It therefore would not be barred by ERISA.

There may also be situations in which it is unclear whether the plan provider is the medical provider as well (or is that provider's employer). Then too, state law may be free from ERISA preemption in ruling on whether what the plan administrator did constituted medical treatment or, what is the same thing, amounted to an employment of medical care

providers. And, if state law so determined, once again a state malpractice suit might lie.[3]

The case before us is, unfortunately, not amenable to any such interpretations. Despite the majority's admirable efforts, the facts, read most favorably to the appellant, are plain. The plan administrators—perhaps because of bad medical judgment, perhaps for other improper reasons—interpreted Mr. Cicio's ERISA-plan contract not to cover the procedure he and his treating physician sought. The treating physician, however, did not give up and in time the plan administrator relented, in part. By then it was too late.

On these facts it seems to me clear beyond peradventure a) that the plan administrators were not, in any way, acting as Mr. Cicio's doctors, b) that what they were doing was—perhaps negligently—determining the scope and coverage of an ERISA-plan contract, c) that as a result of that allegedly improper denial of coverage, Mr. Cicio was financially unable to obtain, in time, the treatment he and his treating physician continued to seek, and d) that catastrophic, consequential damages—Mr. Cicio's death—flowed from

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[3] Indeed, a suggestion could even be made that a) where a treating physical fails to attempt to treat simply *because* the plan administrator denied coverage, and b) that denial was ostensibly made on medical grounds, it may be possible for a state to find that the plan administrators *de facto* controlled the treating physician and hence were responsible—as principals—for that doctor's malpractice as agent. This approach would lead to the seeming paradox that recoveries of consequential damages against the plan administrators might be available when the plaintiff's physician foolishly forwent trying to treat after the administrators denied coverage, while such damages would be precluded when that same physician wisely continued to try to treat and stopped only because the moneys needed for treatment were not available. But the paradox is more apparent than real, since it is always the case that a person who suffers a medical maloccurrence after proper medical treatment is worse off—in terms of legal damages—than one whose medical maloccurrence was due to malpractice.

the improper misreading of the ERISA-plan coverage. Mrs. Cicio then sued for those damages. If this is not a paradigmatic suit to remedy the violation of rights under the terms of the plan, I don't know what is.

The majority tries to make much of the fact that the coverage decision was erroneously made because of a *medical error* on the plan administrator's part. That may well be, but that fact seems to me irrelevant. Indeed, its irrelevance shows why, at best, the majority opinion only band-aids a gaping wound.

Improperly erroneous coverage decisions by plan administrators can be made for any number of reasons, medical and non-medical. The result of such denials of coverage, as a practical matter, often will be, as it allegedly was in this case, the source of disastrous consequential injuries. The ERISA beneficiary gets no money and as a result suffers grievous consequential harms. Such harms are not, however, remediable injuries under ERISA, given the Supreme Court's misguided decision in *Mertens*, 508 U.S. at 255-62 (1993) (holding that "appropriate equitable relief" under ERISA § 502(a)(3) does not encompass compensatory damages). And there is no suggestion in the preemption cases that state suits based on the underlying negligence that gave rise to an erroneous coverage decision can survive under ERISA. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (holding preempted a state-law claim based on allegedly improper processing of benefits).

There is none, that is, except for the unexplained comment in *Pegram*—on which the majority puts such weight—dealing with medically based errors. But that well intentioned dicta can only make sense where the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or

such a physician's employer, as was the case in *Pegram*.[4] Where, as here, no such relationship existed, there is no apparent reason, in state or federal law, for treating the unlawful coverage decision any differently from any other unlawful coverage decision that is *not* based on medical error.

In the end, stretching to avoid preemption in order to allow state actions for consequential damages in cases like this one, in which the wrongful coverage decision was medically based, will help a few deserving people, like Mrs. Cicio. It will, however, leave unaided all those who suffer identical consequential damages as a result of non-medically based wrongful coverage decisions. And there is nothing in ERISA theory or practice that seems to me to justify such different treatment.

III.

The majority reaches a result that I believe to be just *in this case*, and I applaud it. Since that result neither fits with the existing structure of ERISA nor—except occasionally and anecdotally—solves the problem caused by the Supreme Court's denial of consequential damages under ERISA, I respectfully dissent from Part V of the majority's opinion.

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[4] *Pegram*, of course, was not a preemption decision.

208 F. Supp. 2d 288

**United States District Court,**
**E.D. New York.**

Bonnie CICIO, Individually and as administratrix of the Estate of CARMINE CICIO, Plaintiff,

v.

VYTRA HEALTHCARE, BRENT SPEARS, M.D., Individually, and JOHN DOES, 1-8, Defendants.

No. 00-CV-3047(JS)(ETB).

Sept. 28, 2001.

## ORDER ADOPTING REPORT AND RECOMMENDATION

SEYBERT, District Judge.

On June 21, 2000, Defendants moved for an order of dismissal pursuant to Fed. R. Civ. P. 12(b)(6) for failure to state a claim upon which relief may be granted. On June 28, 2000, Plaintiff moved to remand this action to the Supreme Court of the State of New York, Suffolk County, pursuant to 28 U.S.C. § 1447(c). By Order dated August 22, 2000, this Court referred the motion to Magistrate Judge E. Thomas Boyle. The magistrate judge completed his report and recommendation on March 13, 2001, recommending to the Court that the Plaintiff's motion to remand be denied and Defendants' motion to dismiss as to all counts be granted. Plaintiff filed her objections to the Report and Recommendation on March 23, 2001 and Defendants filed papers on April 17, 2001 which urge the Court to adopt the Magistrate's report.

The issues raised arise from Plaintiff's claim that defendant Vytra delayed in approving a tandem double stem cell transplant until it was too late to benefit her husband,

who died of multiple myeloma, a blood cancer, in May of 1998. After Plaintiff initiated an action in state court, wherein she alleged eighteen state causes of action,[1] the Defendants removed the case to federal court, which gave rise to the instant motions.

In his report and recommendation, the magistrate judge, applying the two-prong test for ERISA removal and preemption set forth in *Romney v. Lin*, 94 F.3d 74 (2d Cir. 1996), found that the Plaintiff's state law claims were preempted by ERISA and were within the exclusive scope of ERISA's civil enforcement provisions. *See* Report and Recommendation at 4-10. He then found that although asserted as causes of action for breach of contract, negligence and malpractice under state law, the gravamen of the complaint was an attack on benefits decisions—preempted by ERISA § 514—and, as such, could not be sustained. *Id.* at 11-16. For the reasons discussed below, the report and recommendation is adopted in its entirety, the Plaintiff's motion to remand is denied, Defendants' motion to dismiss is granted, and this case is dismissed with prejudice.

The procedural history of this case is amply set forth in Magistrate Judge Boyle's report, as are the other facts of this case. Thus, pursuant to Fed. R. Civ. P. 72(b), the Court proceeds to a *de novo* review of that "portion of the magistrate judge's disposition to which specific written objection has been made."

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[1] The Complaint alleges claims for medical malpractice, practicing medicine without a license, negligence, gross negligence, tortious interference with the physician-patient relationship, breach of fiduciary duty, misrepresentation, negligent misrepresentation, negligent supervision of employees, negligent infliction of emotional distress, intentional infliction of emotional distress, breach of contract, bad faith breach of insurance contract and deceptive acts and business practices.

In sum, Plaintiff objects to the magistrate judge's determinations that: (1) removal to federal court was proper because her claims relate to an ERISA plan and thus are preempted thereunder; and, (2) dismissal of her claims is warranted. She urges the Court to reject these findings as clearly erroneous. *See* Pltf.'s Aff. in Opp'n ¶ 2; Pltf.'s Memo. of Law at 1, 4-10. Plaintiff advances four arguments: (1) that ERISA does not apply to HMOs and utilization review; (2) that Vytra is not an ERISA plan; (3) that her state law claims arise from improper medical care and should not be construed under ERISA and/or dismissed; and, (4) that her claims against Dr. Spears and John Doe physicians should be remanded because they are not governed by ERISA. These objections are discussed below.

1. ERISA Applies to All of Plaintiff's Causes of Action

In his Report and Recommendation, the magistrate judge found that,

> Plaintiff's policy constitutes an employee welfare benefit plan within the meaning of ERISA. It was a plan established by an employer, North Fork Bank, for the purposes of providing medical benefits through the purchase of insurance. *See* 29 U.S.C. § 1002(I)(A) (definition of an "employee benefit plan").

Report and Recommendation at 8.

Plaintiff takes issue with the magistrate judge's conclusion. Plaintiff's first and second objections are based on her contention that VYTRA's health care plan is not an employee benefit plan such that it falls within the exclusive enforcement provisions of ERISA. She asserts that although Congress intended for ERISA enforcement mechanisms to provide the exclusive remedy for employee pension plans, it did not intend to have ERISA govern claims relating to HMOs, utilization review and other health-plan issues. *See* Pltf.'s Memo. at 3-4. Plaintiff argues that the courts' failure

to acknowledge the distinction between pensions plans and health care plans has led to "unfair and counter-intuitive decisions" which "strip[ ] plaintiffs of their rights." *Id.*

The Court concurs with the magistrate judge's findings and the well-reasoned authority on which he relies. Vytra's health plan is an ERISA "benefit plan" and, as such, Section 514(a) preempts Plaintiff's common law and statutory claims arising from breach of contract, bad faith breach of insurance contract, misrepresentation and negligent misrepresentation under Counts Nine, Ten, Eleven, Fifteen and Sixteen of the Complaint. *See* Report and Recommendation at 8-10. As recognized by the Supreme Court,

> ERISA's comprehensive regulation of employee welfare and pension benefit plans extends to those that provide "medical, surgical, or hospital care or benefits" for plan participants or their beneficiaries "through the purchase of insurance or otherwise." The Federal statute does not go about protecting plan participants and their beneficiaries by requiring employers to provide a given set of minimum benefits, but instead controls the administration of benefit plans.

*N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S. Ct. 1671, 1674 (1995).

In construing the scope of the statute, courts have recognized ERISA's reach over claims arising from a variety of medical and other employee benefit plans. *See, e.g., Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 107 S. Ct. 1542 (1987) (ERISA preemption of tort and contract claims based upon denial of disability benefits); *Zervos v. Verizon New York*, 252 F.3d 163 (2d Cir. 2001) (reviewing denial of insured plaintiff's motion for a preliminary injunction arising from an ERISA dispute over denial of experimental medical treatment); *Kolasinski v. Cigna Healthplan of CT., Inc.*, 163 F.3d 148 (2d Cir. 1998) (ERISA preemption of state law

claims arising from failure to provide insured with compensation for medical treatment); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D.N.Y. 1994) (ERISA governs claims for breach of contract, medical malpractice, wrongful death and misrepresentation based upon delaying husband's medical treatment); *Raff v. Travelers Ins. Co.*, No. 90-CV-7673, 1996 WL 137310, at *3 (S.D.N.Y. Mar. 26, 1996) (recognizing ERISA's extension over claims for breach of contract, conversion and unjust enrichment); *see also Logan v. Empire Blue Cross & Blue Shield*, 275 A.D.2d 187, 194-95, 714 N.Y.S.2d 119 (2d Dep't 2000) (tort and contract claims for denial of experimental Lyme disease treatment preempted by ERISA), *leave to appeal denied*, 96 N.Y.2d 823, 729 N.Y.S.2d 443 (2001).

Plaintiff is mistaken in her contention that "Vytra is not the ERISA" plan and in relying on *Pegram v. Herdrich*, 530 U.S. 211, 120 S. Ct. 2143, 2147 (2000). As noted by the magistrate judge, the "plan" at issue is not Vytra but the agreement between Vytra and Plaintiff's employer which sets forth the rules under which beneficiaries are entitled to benefits. This conclusion is consistent with rather than contrary to *Pegram*, *supra*, wherein the Court recognized that "[r]ules governing . . . definition of benefits, submission of claims, and resolution of disagreements over entitlement over services are the sorts of provisions that constitute a [employee benefit] plan." *Id.* at 223, 120 S. Ct. at 2151. In this case, the Plaintiff's claim arise from a health care policy administered by Vytra which set forth rules and conditions for medical care and which excluded procedures deemed by Vytra's medical director to be experimental. *See* Compl. ¶ 13 & Ex. A. at § 9.3(f).

Accordingly, the Court concurs with the magistrate judge's findings that the subject plan was an employee benefit plan within the meaning of ERISA and that the Plaintiff's claims "relate to" the plan and are thus preempted.

The Plaintiff's first and second objections are unsupported and contrary to controlling authority and are, therefore, DENIED.

2. Dismissal is Warranted because all of the claims are Preempted by ERISA Because they Arise from Administration of the Plan

As and for her third and fourth objections, Plaintiff argues that the magistrate misunderstood that, in fact, she alleges claims for improper medical care which are not preempted under ERISA. *See* Pltf.'s Memo. of Law at 6-7. Relying again on *Pegram*, *supra*, Plaintiff argues that mixed eligibility decisions such as those at issue here are not preempted. *See id.* at 8.

Plaintiff misconstrues *Pegram*, which involved a physician owned-and- operated HMO and a claim for breach of fiduciary duty within the meaning of 29 U.S.C. § 1109(a).[2] In *Pegram*, the Supreme Court noted that "pure 'eligibility decisions' turn on the plan's coverage of particular condition or medical procedure for treatment. 'Treatment decisions,' by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellations of symptoms, what is the appropriate medical response?" *Id.* at 228, 120 S. Ct. at 2154. On the facts presented, the Court considered whether the inherent conflict of interest implicated when treating

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[2] Section 1109 provides that "[a]ny person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary." 29 U.S.C. § 1109(a).

physicians derive financial benefit from withholding care automatically gives rise to a breach of fiduciary duty.

This case is distinguishable on its facts. The magistrate judge, while recognizing that a degree of medical judgment was necessarily implicated, correctly determined that the utilization review determination which gave rise to the instant Complaint involves eligibility for coverage such that Defendants' roles, including that of Dr. Spears, were administrative. *See* Report and Recommendation at 14 (citing *Pegram*).

The Plaintiff does not cite any authority for her proposition that Vytra, the plan administrator, engaged in the practice of medicine when it reached its benefits determination. The magistrate judge correctly noted the distinction between true medical malpractice claims arising from negligent treatment (Report and Recommendation at 13-14, citing *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 153 (10th Cir. 1995)) and claims for wrongful denial of coverage for care recommended by a treating physician which are preempted by ERISA (*id.*, citing *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 506 U.S. 1033, 113 S. Ct. 812 (1992)). In fact, in recommending dismissal of the claims, the magistrate noted two district court cases in this Circuit wherein state-law causes of action were dismissed on ERISA preemption grounds on nearly identical facts. *See id.* at 15-16 (citing *Brandon v. Aetna Servs., Inc.*, 46 F. Supp. 2d 110, 113-14 (D.Conn. 1999); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D.N.Y. 1994)).

The Court concurs with the magistrate judge's determination that all of the Plaintiff's state law claims center on Vytra's refusal to approve coverage and thus stem from an adverse benefits determination such that the claims are preempted by ERISA. The Plaintiff's third and fourth objections are, therefore, DENIED.

## CONCLUSION

Having conducted a *de novo* review of Magistrate Judge Boyle's March 13, 2001 Report and Recommendation, Plaintiff's objections thereto, and all other submissions made in connection with Plaintiff's motion to remand and Defendants' motion to dismiss, the Court ADOPTS the Report and Recommendation in its entirety. Plaintiff's Motion to Remand is DENIED and Defendants' motion to dismiss is GRANTED. The Clerk of the Court is directed to close this case.

SO ORDERED.

/s/

Joanna Seybert, U.S.D.J.

Dated: Central Islip, New York
September 28, 2001

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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BONNIES CICIO, individually and as adminsitratrix of the Estate of CARMINE CICIO,

Plaintiff,

-against-

VYTRA HEALTHCARE, BRENT SPEARS, M.D., individually, and JOHN DOES, 1-18

Defendants.

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CV-00-0347(JS)

**REPORT AND RECOMMENDATION**

Plaintiff Bonnie Cicio brings suit against Vytra Healthcare ("Vytra"), a health maintenance organization ("HMO"), Vytra's Medical Director, Dr. Brent Spears, M.D., and eight unidentified individuals ("John Does 1-8"). Defendants removed this action to federal court and now seek an order of dismissal pursuant to Federal Rule of Civil Procedure 12(b)(6) on the grounds that Plaintiff's claims are preempted by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.* Plaintiff maintains that her claims are state claims not preempted by ERISA and moves for an order of remand. The above motions were referred to the undersigned by the Honorable Joanna Seybert, United States District Judge, by order dated August 22, 2000 for a report and recommendation.

## FACTS

Plaintiff was employed by North Fork Bank and received health insurance coverage for herself and her husband, Carmine Cicio, through an insurance policy purchased by North Fork Bank. Vytra administered the policy. (Compl., ¶¶ 9-11.)

According to Plaintiff, Carmine Cicio was diagnosed with multiple myeloma, a type of blood cancer, in March 1997. (*Id.*, ¶ 14.) On January 28, 1998, Dr. Edward Samuel, Mr. Cicio's oncologist, wrote Vytra requesting that Mr. Cicio receive a tandem double stem cell transplant, a treatment which Dr. Samuel described as medically necessary and possibly life-saving. (*Id.*, ¶ 15.) In a letter dated February 23, 1998 from Dr. Spears, Vytra's Medical Director, Vytra denied the request, stating that a-double stem cell transplant was an "experimental/investigational" procedure and thus not covered under Mr. Cicio's policy. (*Id.*, ¶¶ 19, 21.) Mr. Cicio, through Dr. Samuel, appealed Vytra's decision in writing on March 4, 1998, which resulted in Vytra's approval of a single stem cell transplant on March 25, 1998.[1] (*Id.*, ¶¶ 25, 29.) However, according to Plaintiff, the window of opportunity for the effectiveness of the treatment had passed by the time Vytra approved coverage for a single stem cell transplant on March 25, 1998. Mr. Cicio died approximately six weeks later.

On May 3, 2000, Plaintiff commenced this action against Defendants in the Supreme Court of the State of New York, Suffolk County alleging eighteen causes of action arising under New York state law. The theories of liability include:

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[1] Plaintiff also alleges that Dr. Samuel attempted to appeal Vytra's decision by telephone on the days immediately following his receipt of Vytra's letter denying Mr. Cicio's request. Dr. Samuel left several messages for Dr. Spears, none of which were returned. (Compl., ¶¶ 22-26.)

medical malpractice, practicing medicine without a license, negligence, gross negligence, tortious interference with the physician-patient relationship, breach of fiduciary duty, misrepresentation, negligent misrepresentation, negligent supervision of employees, negligent infliction of emotional distress, intentional infliction of emotional distress, breach of contract, bad faith breach of insurance contract, and deceptive acts and business practices under § 349 of the New York General Business Law ("GBL"). On May 30, 2000, Defendants filed a notice of removal on the basis that Plaintiff's claims relate to an "employee welfare benefit plan" as defined by ERISA. *See* 29 U.S.C. § 1002(3) (definition of "employee welfare benefit plan").

On June 21, 2000, Defendants moved for an order of dismissal pursuant to Fed. R. Civ. P. 12(b)(6) for failure to state a claim upon which relief may be granted. On June 28, 2000, Plaintiff moved to remand this action to the Supreme Court of the State of New York, Suffolk County pursuant to 28 U.S.C. § 1447(c).

## DISCUSSION

### I. Removal Jurisdiction

Removal jurisdiction under 28 U.S.C. § 1441 exists when a federal district court has original subject-matter jurisdiction over the plaintiff's claim. *See* 28 U.S.C. § 1441; *Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269, 271 (2d Cir. 1994). Under 28 U.S.C. § 1447(c), a district court must remand an action to state court "[i]f at any time before final judgment it appears that the district court lacks subject-matter jurisdiction." 28 U.S.C. § 1447(c); *Lupo*, 28 F.3d at 271. A district court's assessment of subject matter jurisdiction for the purposes of determining removal jurisdiction is governed by the well-pleaded complaint rule. *See Lupo*, 28 F.3d at 272 ("[I]n addressing the substantive jurisdictional issue, the initial matter before us is the application of the well-pleaded complaint rule"); *Romney v. Lin*, 94 F.3d 74, 79 (2d Cir.

1996) ("'[i]t is long settled law that a cause of action arises under federal law only when the plaintiff's well-pleaded complaint raises issues of federal law'") (*quoting Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63, 107 S.Ct. 1542, 1546, 95 L.Ed.2d 55 (1987)).

The well-pleaded complaint rule limits the search for federal subject matter jurisdiction to "'what necessarily appears in the plaintiff's statement of his own claim in the bill or declaration, unaided by anything alleged in anticipation or avoidance of defenses which it is thought the defendant may interpose.'" *See Lupo*, 28 F.3d at 272 (*quoting Taylor v. Anderson*, 234 U.S. 74, 75-76, 34 S.Ct. 724, 725, 58 L.Ed. 1218 (1914)). Courts have also recognized an important corollary to the well-pleaded complaint rule, known as the complete preemption doctrine, which provides that, "Congress may so completely preempt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Metropolitan Life Ins. Co.*, 481 U.S. at 63-63, 107 S.Ct. 1546.

The well-pleaded complaint rule and the complete preemption doctrine have particular relevance to actions removed to federal court by the defendant on the basis of ERISA preemption. In *Romney v. Lin*, 94 F.3d 74 (2d Cir. 1996), the Second Circuit held:

> [A] state-law cause of action arises under federal law within the meaning of 28 U.S.C. § 1331, and is removable under 28 U.S.C. § 1441, if (1) the cause of action is based on a state law that is preempted by ERISA, and (2) the cause of action is 'within the scope of the civil enforcement provisions of ERISA § 502(a)'. That is because Congress specifically intended to exert 'extraordinary preemptive power' when it adopted the detailed provisions of ERISA § 502(a).

*Romney*, 94 F.3d at 78 (internal citations omitted). "[P]reemption is therefore one requisite of removal jurisdiction, as well as the key to the merits." *Id.* State-law causes of action may not be removed to federal court solely on the theory of ERISA preemption. *See id.* ("Preemption alone is insufficient to support removal jurisdiction.") The second prong of the *Romney* test is that the state-law claim falls within the scope of the civil enforcement provisions of ERISA § 502(a).

Because the preemption issue also deals with the merits, we address the latter condition first.

**(1) "Within the Scope of" ERISA § 502(a)**

ERISA § 502(a), in relevant part, provides:

> A civil action may be brought—
>
> (1) by a participant or beneficiary
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan

29 U.S.C. § 1132(a)(1)(B). Congress intended for the civil enforcement mechanisms created under § 502(a) to be the exclusive remedy for rights guaranteed by ERISA. ERISA § 502(a) "represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Romney*, 94 F.3d at 80 (*quoting Ingersoll-Rand v. McClendon*, 498 U.S. 133, 144, 111 S.Ct. 478, 485, 112 L.Ed.2d 356 (1990) and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 42, 54, 107 S.Ct. 1549, 1556, 95 Led.2d 39 (1987)). ERISA defines an "employee welfare benefit plan" as:

> any plan, fund or program which was . . . established or maintained by an employer . . . for the purposes of

> providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . .

29 U.S.C. § 1002(1)(A). In *Romney*, the Second Circuit reaffirmed its holding in *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 10-11 (2d Cir. 1992), that common law claims for breach of contract and negligent misrepresentation to enforce an oral promise to pay pension related-benefits fell within the scope of ERISA § 502(a). *See Romney*, 94 F.3d at 80 (ERISA § 502 provides a cause of action to enforce employer contributions to ERISA plans); *Smith*, 959 F.2d at 10-11. Counts Nine and Ten of the Complaint allege that Vytra intentionally or recklessly misconstrued the terms of Mr. Cicio's policy, "knowingly decided not to perform its obligations under the Policy," and "adopted inconsistent and incorrect interpretations of the term 'medical necessity' and other terms contained in the Policy." (Compl., ¶¶ 82, 89, 90.) Also, Count Eleven alleges that Vytra made "negligent misrepresentations about the scope of coverage under the Policy." (*Id.*, ¶ 97.) Finally, Counts Fifteen and Sixteen allege that Vytra breached, in bad faith, the terms of an enforceable insurance contract "by failing to approve and provide care recommended by her treating physician as consistent with provisions of the policy and by delaying approval and provision of care recommended by her treating physician in contradiction to the contract." (*Id.*, ¶¶ 120, 124.)

It is apparent from these allegations that Plaintiff is seeking to enforce the terms of the plan and specifically those terms that deal with medical necessity and experimental procedures. However, as it has been recognized time and time again, ERISA § 502(a) provides the exclusive remedy for beneficiaries seeking to enforce the terms of an employee welfare benefit plan as defined by

ERISA. *See, e.g., Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D.N.Y. 1994) (claims for breach of contract and misrepresentation fall within the scope of § 502(a)); *Raff v. Travelers Ins. Co.*, 1996 WL 137310, at *3 (S.D.N.Y. 1996) (breach of contract, conversion, and unjust enrichment claims fall within the scope of § 502(a)). Accordingly, Plaintiff's claims for breach of contract and misrepresentation contained in Counts Nine, Ten, Eleven, Fifteen and Sixteen of the Complaint fall within the exclusive provisions of ERISA's civil enforcement scheme in § 502(a).

Relying on *Pegram v. Herdrich*, -- U.S. --, 120 S.Ct. 2143 (2000), Plaintiff argues that the claims alleged in the Complaint do not fall within the scope of § 502(a) because Vytra, as a HMO, is not a "plan" within the meaning of ERISA. In *Pegram*, the defendant HMO provided financial incentives to the physician owners as a reward for reducing the cost of patient care. The plaintiffs argued that this internal arrangement breached the fiduciary duties owed by the defendants to their subscriber patients. *See Pegram*, 120 S.Ct. at 2147. The Court clarified that:

> when employers contract with an HMO to provide benefits to employees subject to ERISA, the provisions of those documents that set up the HMO are not, as such, an ERISA plan, but the agreement between an HMO and an employer who pays the premiums may, as here, provide elements of a plan by setting out rules under which beneficiaries will be entitled to care.

*Id.* at 2151. Thus, an agreement between an employer and an HMO, which articulates the rules under which the beneficiaries are entitled to certain benefits, constitutes an employee welfare benefit plan within the meaning of ERISA. *See id.* ("Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a [employee welfare benefit]

plan.") However, the HMO itself, and the documents that set up the HMO do not constitute the plan. *See id.*

According to Plaintiff, her employer, North Fork Bank, purchased a health insurance policy administered by Vytra to provide health care benefits for North Fork employees. (Compl., ¶¶ 9-11.) The policy, entitled "Agreement for Comprehensive Health Services," outlined the rules and conditions under which members and beneficiaries received insurance coverage for medical care. (*See* Compl., Ex. A.) The policy expressly provided coverage for "medically necessary" services, and excludes "[a]ny procedure or service which in the judgment of Vytra's Medical Director, is experimental or is not generally recognized to be effective for a particular condition, diagnosis or body area." (*Id.*, ¶ 13 & Ex. A at § 9.3(f)).

Plaintiff's policy constitutes an employee welfare benefit plan within the meaning of ERISA. It was a plan established by an employer, North Fork Bank, for the purposes of providing medical benefits through the purchase of insurance. *See* 29 U.S.C. § 1002(1)(A) (definition of an 'employee welfare benefit plan'). Contrary to Plaintiff's arguments, the result is no different in light of *Pegram*, which reaffirmed that rules governing the definition of benefits and submission of claims qualify as an employee welfare benefit plan. *See Pegram*, 120 S.Ct. at 2151.

**(2) ERISA Preemption under § 514(a)**

Having determined that several of Plaintiff's state-law claims fall within the ambit of § 502(a), the court now turns to the other requirement under the *Romney* test, which examines whether state-law causes of action "relate to" an ERISA plan, thereby triggering federal preemption. *See Romney*, 94 F.3d at 78. As noted above, a finding that these causes of action fall within the scope of § 502(a) and "relate to" an ERISA plan confirms the appropriateness of removal. *See id.*

ERISA's preemption clause found in § 514(a) is intentionally broad:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

29 U.S.C. § 1144(a); *see New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 651, 115 S.Ct. 1671, 1677, 131 L.Ed.2d 695 (1995). ERISA stops short of preempting "any law of any State which regulates insurance," although even this exception is limited "by the provision that an employee benefit plan may not 'be deemed to be an insurance company or other insurer . . . or to be engaged in the business in insurance.'" *Travelers Ins. Co.* ("*Travelers*"), 514 U.S. at 651, 115 S.Ct. at 1677 (*quoting* 29 U.S.C. § 1144(b)(2)(A) & (B)). ERISA also does not preempt "any generally applicable criminal law of a State." 29 U.S.C. § 1144(b)(4).

In *Travelers*, the Court acknowledged the difficulty in construing the phrase "relate to" because "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course." *Travelers*, 514 U.S. at 655, 115 S.Ct. at 1677. Despite this difficulty, the Court explained that, "'[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan,'" and that the objectives of the ERISA statute may be used as guide in determining the scope of the state law that survives preemption. *Id.*, 514 U.S. at 656, 115 S.Ct. at 1677 (*quoting Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983)).

Although the Court's analysis in *Travelers* excluded from the scope of ERISA preemption state claims that have an indirect, tenuous or remote relationship to ERISA, *Travelers* does not disturb the Court's decisions where the Court has held that "state laws providing alternative enforcement mechanisms also relate to ERISA plans, triggering pre-emption." *Id.* (*citing Ingersoll-Rand*, 498 U.S. at 142, 111 S.Ct. at 484). In the instant case, Plaintiff is attempting to enforce the health plan in a manner outside the exclusive scope of ERISA's civil enforcement scheme by alleging that Vytra failed to perform its obligations under the policy and intentionally misconstrued the terms of the policy. By circumventing § 502(a), Plaintiff triggers ERISA preemption under § 514(a). *See Kolasinski v. Cigna Healthplan of CT., Inc.*, 163 F.3d 148, 149 (2d Cir. 1998) (ERISA § 514(a) preempts common law breach of contract and unfair trade practices claims brought by a plaintiff who was seeking compensation from his insurance provider who had agreed to provide coverage for "medically necessary services"); *Saks v. Franklin Covey, Co.*, 117 F.Supp.2d 318, 330 (S.D.N.Y. 2000) ("[I]t has long been held that a plaintiff has no claim for breach of contract against a plan administrator for failing to award benefits, because such claims are squarely preempted by ERISA.")

Based on the foregoing discussion, I find that § 514(a) of ERISA preempts Plaintiff's common law or statutory claims for breach of contract, bad faith breach of insurance contract, misrepresentation and negligent misrepresentation contained in Counts Nine, Ten, Eleven, Fifteen and Sixteen of the Complaint. Therefore, Defendants have shown that a federal question exists in this action, and accordingly, this case has been properly removed. For the purposes of deciding Plaintiff's motion to remand, we do not need to determine whether the remaining counts in the Complaint also satisfy the *Romney* test. Because the court has original jurisdiction over this action, and the remaining counts arise out of the same case or controversy, the court may exercise

supplemental jurisdiction over the remaining counts, in the event that they are not pre-empted by ERISA § 514(a), an issue addressed below in the context of Defendants' Rule 12(b)(6) motion to dismiss. *See* 28 U.S.C. § 1367 (supplemental jurisdiction). Thus, for the reasons stated above, I recommend that Plaintiff's motion to remand be denied.

## II. Rule 12(b)(6) Motion to Dismiss

For the purposes of Defendants' Rule 12(b)(6) motion to dismiss, the allegations of the Complaint are deemed to be true and the court "must draw all reasonable inferences in favor of the plaintiff." *Hamilton Chapter of Alpha Delta Phi, Inc. v. Hamilton College*, 128 F.3d 59, 63 (2d Cir. 1997); *Giglio v. Dunn*, 732 F.2d 1133, 1133 (2d Cir. 1984).

### A. ERISA Preemption under § 514(a)

Congress intended for ERISA to regulate all aspects of employee welfare benefit programs. *Saks*, 117 F. Supp.2d at 330. As explained above, ERISA § 514(a) preempts all state laws that "relate to" an employee benefit plan, with a few statutory exceptions. As also discussed previously, Counts Nine, Ten, Eleven, Fifteen and Sixteen of the Complaint purport to create alternative theories of recovery outside the exclusive scope of ERISA's civil enforcement scheme, thereby triggering preemption under § 514(a). Accordingly, these counts should be dismissed.

Defendants argue that Plaintiff's remaining causes of action should also be dismissed on the grounds that they "relate to" an employee benefit plan and are preempted by ERISA. I now turn to a discussion of these remaining counts.

**B. State-Law Claims**

**(1) Medical Malpractice, Practicing Medicine without a License, Tortious Interference with the Physician-Patient Relationship, Negligence, Gross Negligence, Negligent Supervision of Employees, Breach of Fiduciary Duty, Intentional Infliction of Emotional Distress, Negligent Infliction of Emotional Distress (Counts One, Two, Three, Four, Five, Six, Seven, Eight, Twelve, Thirteen, Fourteen, Eighteen)**

All of the remaining claims center around Vytra's refusal to approve coverage for the treatment recommended by Mr. Cicio's treating physician and Vytra's alleged failure to render its decision in a timely manner. Briefly summarizing the nature of these claims, Count One alleges a claim for medical malpractice against Vytra. (Compl., ¶¶ 33-37) This claim alleges that Vytra failed to exercise reasonable care and provide treatment consistent with the standards of the medical profession, including the failure to adequately provide medically necessary treatment. (*Id.*) Count Four is a medical practice claim against Dr. Spears and his unnamed colleagues who allegedly failed to provide reasonable care in accordance with the ordinary medical standards. (*Id.*, ¶¶ 54-57.) Count Seven alleges that Defendants' failure to provide approval for a double cell stem transplant interfered with Mr. Cicio's relationship with his treating physician, Dr. Samuel. (*Id.*, ¶¶ 69- 76.)

Counts Two and Three allege that Vytra engaged in the unlawful practice of medicine without a license when Vytra allegedly made determinations as to the medical necessity of the requested treatment for Mr. Cicio. In Count Three, Plaintiff asserts that New York Public Health Law § 4410, which declares that "the provision of comprehensive health services directly or indirectly, by a health maintenance organization through its comprehensive health services plan

shall not be considered the practice of the profession of medicine by such organization or plan," violates the New York Constitution. (*Id.*, ¶¶ 38-53, *citing* N.Y. Pub. Health L. § 4410).

Counts Five and Six allege that all Defendants acted negligently and were grossly negligent by failing to approve coverage for the requested treatment and by failing to consider the request for treatment in a timely manner. (*Id.*, ¶¶ 58-68.) Count Twelve alleges that Vytra failed to use reasonable care in the supervision of Vytra's employees who made determinations regarding Mr. Cicio's coverage request. (*Id.*, ¶¶ 103-106.)

Count Eight alleges that Defendants breached their fiduciary duty to Mr. Cicio by failing to provide him with medically necessary care as recommend by his doctor and in a timely manner. (*Id.*, ¶¶ 77-81.) Counts Thirteen and Fourteen allege that Vytra negligently and intentionally inflicted emotional distress on the Plaintiff by failing to approve coverage for the treatment requested and by failing to make a determination within a timely manner. (*Id.*, ¶¶ 107-117.) Finally, Count Eighteen alleges that Vytra should be permanently enjoined from placing arbitrary limits on medical necessity determinations based on financial incentives. (*Id.*, ¶¶ 130-136.) All of these counts stem from an adverse benefits determination (i.e. Vytra's refusal to approve coverage for the treatment recommended by Mr. Cicio's treating physician in a timely manner).

Plaintiff argues that Vytra is a medical service provider and the decisions Vytra took were medical and not administrative. In Plaintiff's view, Vytra provided direct medical services in a role identical to that of Dr. Samuel, Mr. Cicio's oncologist. Plaintiff argues that her contentions regarding the medical nature of Vytra's determination are supported by the Court's discussion of "mixed eligibility and treatment decisions" in *Pegram*. *See Pegram*, 120 S.Ct. at 2153-2155. In *Pegram*, the Court differentiated between

"pure eligibility," "treatment," and "mixed eligibility and treatment" decisions. *See id.* Eligibility decisions turn on a plan's coverage of a particular condition while treatment decisions are choices about diagnosing and treating a patient's condition. Often times, these decisions are intertwined with each other, resulting in mixed questions of eligibility and treatment. *See id.* at 2153. ("The eligibility decision and the treatment decision were inextricably mixed, as they are in countless medical administrative decisions every day.") These distinctions are noteworthy because eligibility decisions are preempted by ERISA while treatment decisions generally are not. *Compare, e.g., Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 153 (10th Cir. 1995) (ERISA does not preempt medical malpractice claim challenging quality of care provided by treating physician) *with Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (ERISA preempts medical malpractice claim against plan administrator for wrongfully denying coverage for care recommended by treating physician).

*Pegram* is not controlling here, even though the complained of decision—Vytra's determination that a tandem double stem cell transplant was an experimental/ investigational procedure—may qualify as a mixed eligibility and treatment decision. *See Pegram*, 120 S.Ct. at 2154-55 (determination concerning "the experimental character of a proposed course of treatment" is a mixed eligibility and treatment decision).

In *Pegram*, the defendant HMO was a direct medical services provider. The treating physician and HMO were one in the same. *See id.* at 2147. Here, Vytra acted solely in the role of a plan administrator and was not the medical services provider. Vytra's role was limited to determining whether the proposed treatment qualified as an experimental procedure under the terms of the plan. Although Vytra's benefits determination may have involved some medical

judgment, this may be said of countless medical administrative made decisions every day. *See id.* at 2153. There is no evidence that Congress intended that these quasi-medical/administrative decisions made by a plan administrator survive ERISA preemption. Vytra's coverage determination cannot be separated or construed apart from the ERISA plan. Vytra functioned solely as a plan administrator and bore no responsibility as a provider of medical services in this action. For this reason, the challenge here does not target the quality of care but rather attacks the benefits decision that was made. This determination is preempted by ERISA. *See Saks*, 117 F.Supp.2d 318, 329-330 (ERISA preempts the plaintiff's state law claims against the plan administrator for refusing to compensate the plaintiff for "medically necessary" treatment and for violations of New York's Human Rights Law).

The Court of Appeals for the Second Circuit has not yet addressed the issue of whether state-law claims arising from an adverse mixed eligibility and treatment decision made by a plan administrator is preempted by ERISA. However, a decision from the Fifth Circuit, *Corporate Health Ins. v. Texas Dep't of Ins.* ("*Corporate Health II*"), 220 F.3d 641 (5th Cir. 2000) is the only Circuit to consider the issue. Corporate Health, an HMO, challenged a Texas law, which, *inter alia*, created an independent review procedure ("IRO") for medical necessity determinations made by an HMO. *See Corporate Health v. Texas Dep't of Ins.* ("*Corporate Health I*"), 215 F.3d 526, 534-35 (5th Cir. 2000). The court held that ERISA preempted those provisions of the Texas law that provided for an independent review of medical necessity determinations made by an HMO. *See id.* The Texas Department of Insurance filed a motion for panel rehearing and petition for rehearing *en banc*, both of which were denied. *See Corporate Health II*, 220 F.3d at 645. The court stated, "[W]e do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment."

*Id.* at 645. Ultimately, the court decided that the IRO provisions were plainly a state regime for reviewing benefit decisions and not a system for regulating a minimum standard of care.

Plaintiff cites to cases where medical malpractice and related claims survive ERISA preemption, but in those cases the defendant is the treating physician and/or his employer or agent. *See e.g.*, *Lupo*, 28 F.3d at 269; *Moscovitch v. Danbury Hosp.*, 25 F.Supp.2d 74 (D.Conn. 1998). Moreover, two district court cases in this circuit have dismissed state-law causes of action against plan administrators on the grounds of ERISA preemption on facts nearly identical to those alleged herein. *See Brandon v. Aetna Servs., Inc.*, 46 F.Supp.2d 110, 113-114 (D.Conn. 1999) (the plaintiff alleged a medical malpractice claim against plan administrator for failure to approve coverage for six months of psychiatric treatment where administrator had agreed to provide coverage for medically necessary services and the plaintiff's treating physician recommended such treatment); *Nealy*, 844 F.Supp. 966, 974 (S.D.N.Y. 1994) (ERISA preempted state law claims for medical malpractice, wrongful death, loss of consortium, and breach of fiduciary duties where plan administrator and medical director did not provide direct medical services). Accordingly, I recommend that the Defendants' motion to dismiss be granted as to Counts One, Two, Three, Four, Five, Six, Seven, Eight, Twelve, Thirteen, Fourteen, and Eighteen because they "relate to" an ERISA plan, and therefore are preempted by ERISA § 514.

**(2) Deceptive Business Practices Claim**

Plaintiff alleges in Count Seventeen that Defendants "knowingly misrepresented to Mr. Cicio and other consumers pertinent facts or policy provisions relating to insurance coverage issues" in violation of § 349 of the GBL. Plaintiff cites *Aetna U.S. Healthcare v. Maltz*, 1999 WL 285545 (S.D.N.Y. 1999), in support of her position that a

§ 349 claim for deceptive business practices survives ERISA preemption. The court disagrees. In *Maltz*, the court found that the plaintiff's allegations concerned misrepresentations about the *quality* of care plan beneficiaries would receive, the alleged misrepresentations were made in independent promotional advertisements, and the claims could be resolved without interpreting the terms of the policy. *See Maltz*, 1999 WL 285545 at *4. In the instant case, Plaintiff makes no such allegations, and is exceedingly vague concerning the alleged misrepresentations. There is no indication that they concern the quality of the care promised. To the contrary, Plaintiff claims that the misrepresentations are "relating to insurance coverage." (Compl., ¶ 128.) In light of these facts, Plaintiff's deceptive business practices claim "relate[s] to" an ERISA plan, namely Mr. Cicio's health plan, within the meaning of § 514(a) and should be pre-empted. In addition, even assuming arguendo that ERISA preemption did not apply, Plaintiff has not stated a § 349 claim under state law. *See Maltz v. Aetna U.S. Healthcare, Inc.*, 270 A.D.2d 68, 704 N.Y.S.2d 562 (2000) (HMO plan enrollees challenging HMO's promotional advertisements as a deceptive business practice following an adverse coverage determination did not state a claim under § 349). Therefore, I recommend that Defendants' motion to dismiss be granted as to this claim, also.

## RECOMMENDATION

For the foregoing reasons, I recommend that Plaintiff's motion to remand be denied and Defendants' motion to dismiss as to all counts be granted.

## OBJECTIONS TO THIS REPORT AND RECOMMENDATION

Any objections to this Report and Recommendation must be filed with the Clerk of the Court with a copy to the undersigned within ten (10) days of the date of entry of this report. Failure to file objections within ten (10) days will

preclude further appellate review of the District Court's order. 28 U.S.C. § 636(b)(1); Fed. R. Civ. P. 6(a), 6(e), and 72(b); *IUE AFL-CIO Pension Fund v. Herrmann*, 9 F.3d 1049, 1054 (2d Cir. 1993), *cert. denied*, 513 U.S. 822 (1994); *Frank v. Johnson*, 968 F.2d 298 (2d Cir.), *cert. denied*, 506 U.S. 1038 (1992); *Small v. Secretary of Health and Human Serv.*, 892 F.2d 15, 16 (2d Cir. 1989) (per curiam).

SO ORDERED.

Dated: March 13, 2001.
Central Islip, New York

/s/
E. Thomas Boyle
United States Magistrate Judge

**UNITED STATES COURT OF APPEALS**
**FOR THE SECOND CIRCUIT**
**UNTED STATES COURTHOUSE**
**40 Foley Square**
**New York 10007**

At a stated term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse, Foley Square, in the City of New York, on the 21st day of April, two thousand three.

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BONNIE CICIO, individually and as Administratix of the Estate of Carmine Cicio,

Plaintiff-Appellant,

v.

Docket No. 01-9248

VYTRA HEALTHCARE and BRENT SPEARS, M.D.

Defendants-Appellees,

JOHN DOES 1-8,

Defendants.

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A petition for panel rehearing and a petition for rehearing en banc having been filed from an opinion herein by appellees, Vytra Healthcare and Brent Spears, M.D.

Upon consideration by the panel that decided the appeal, it is ordered that said petition for rehearing is **DENIED**.

It is further noted that the petitions for rehearing en banc have been transmitted to the judges for the Court in regular active service and to any other judge that heard the appeal and that no such judge has requested that a vote be taken thereon.

**FOR THE COURT**
ROSEANN B.
MACKECHNIE

By: /s/
Arthur Heller,
Administrative Attorney

**UNITED STATES COURT OF APPEALS**
**FOR THE SECOND CIRCUIT**

**MANDATE**

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse, Foley Square, in the City of New York, on the 12th day of March, two thousand and three.

Before: Hon. Guido Calabresi,
Hon. Robert D. Sack,
Hon. B. D. Parker, Jr.,
*Circuit Judges*

Docket No. 01-9248

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BONNIE CICIO, individually and as Administratix of the Estate of Carmine Cicio,

Plaintiff-Appellant,

v.

JOHN DOES 1-8,

Defendants,

VYTRA HEALTHCARE and BRENT SPEARS, M.D.

Defendants-Appellees.

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Appeal from the United States District Court for the Eastern District of New York.

This cause came on to be heard on the transcript of record from the United States District Court for the Eastern District of New York and was argued by counsel.

On consideration whereof, it is hereby ORDERED, ADJUGED and DECREED that the judgment of said district court be and it hereby is AFFIRMED in part, VACATED in part and REMANDED for further proceedings in accordance with the amended opinion of this Court.

**FOR THE COURT**
ROSEANN B.
MACKECHNIE, Clerk

By: /s/
Arthur Heller,
Administrative Attorney

**UNITED STATES DISTRICT COURT**
**EASTERN DISTRICT OF NEW YORK**

BONNIE CICIO, individually and as Administratix of the Estate of Carmine CICIO,

Plaintiff,

-against-

JUDGMENT
CV 00-3047 (JS)

VYTRA HEALTHCARE, BRENT SPEARS, M.D., Individually, and JOHN DOES 1-8

Defendants.

An Order of Hon. Joanna Seybert, United States District Judge, having been filed on September 28, 2001, adopting in its entirety, the Report and Recommendation of Magistrate Judge E. Thomas Boyle, dated March 13, 2001; and denying plaintiff's motion to remand and, granting defendants motion to dismiss, it is

ORDERED AND ADJUDGED that plaintiff take nothing of the defendants; that the Report and Recommnedation of United States Magistrate Judge E. Thomas Boyle is adopted in its entirety; that plaintiff's motion to remand is denied; and that the defendants motion to dismiss is granted.

ROBERT C. HEINEMANN
Clerk of the Court

By: /s/
Deputy Clerk

Dated: Central Islip, NewYork
October 4, 2001

**UNITED STATES DISTRICT COURT**
**EASTERN DISTRICT OF NEW YORK**

BONNIE CICIO, individually and as administratix of the Estate of CARMINE CICIO,

Plaintiff,

v.

VYTRA HEALTHCARE and BRENT SPEARS, M.D., Individually, and JOHN DOES 1-8

Defendants.

Docket No.: CV 00-3047 (JS)

NOTICE OF APPEAL

Notice if hereby given that plaintiff, Bonnie Cicio, individually and as administratix of the Estate of Carmine Cicio, hereby appeals to the United States Court of Appeals for the Second Circuit from the judgment dated September 28, 2001, entered on the docket on October 4, 2001 and signed by the Honorable Joanna Seybert, entering judgment in favor of the defendants against the plaintiff.

Dated: Mineola, New York
October 26, 2001

/s/

DAVID L. TRUEMAN
Attorney for Plaintiff
221 Mineola Boulevard
Mineola, New York 11501

JOEL J. ZIEGLER
Attorney for Plaintiff
199 East Main Street
Box 829
Smithtown, New York 11787

**Agreement for Comprehensive Health Services**

This is your Subscriber Agreement with Vytra Healthcare Long Island, Inc. It is issued to the subscriber named on the Vytra identification card. It entitles the Subscriber (and Eligible Dependents if the Subscriber has selected family coverage) to comprehensive health services provided by this agreement. Coverage begins on the effective date stated on the identification card.

* * *

**Article I**
**Definitions**

* * *

**Section 1.20**

"Medically Necessary" means a determination made in accordance with well-established professional medical standards that Vytra Services are:

(i) consistent with an essential for diagnosis and treatment of the member's condition, disease, ailment or injury;

(ii) the most appropriate supply or level of service which can be provided safely;

(iii) provided for the diagnosis or the direct care treatment of the Member's condition, disease, ailment or injury; and

(iv) when applied to hospitalization, means further that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition and that the Member cannot receive safe or adequate care as an outpatient.

* * *

**Article III**
**Medical and Health Services**

* * *

**Section 3.5**
**Limitations**

Health and medical services from a Participating Physician shall be limited as follows:

(a) Vytra shall provide only Medically Necessary Vytra Services which are provided, directed, authorized or arranged by a Primary Care Physician. As special in this Agreement, certain Vytra Services from a Non-Participating Physician also require Prior Approval.

(b) Exclusions set forth in ARTICLE IX.

* * *

**Article IX**
**Limitations and Exclusions**

* * *

**Section 9.3**
**Types of Non-Covered Services**

Vytra Services shall not include and Vytra shall have no obligation for the following services or conditions:

(a) Health, medical and Hospital services for military services connected disabilities which are an obligation of the Veterans Administration and for which adequate facilities are available in this area;

(b) Physical exams and diagnostic testing for certification of health not required by a Physician for the provision of Vytra Services, such as pre-employment, pre-marital, licensure, insurance, camp, school, adoption, and similar exams;

(c) Procedures for the purpose of reversing voluntary sterilizations;

(d) In Vitro fertilization, artificial insemination or other artificial means of conception;

(e) Hospital, surgical, laboratory and other expenses incurred by a Non-Member donor for an authorized transplant to a Member;

(f) Any procedure or service which, in the judgment of Vytra's Medical Director, is experimental or is not generally recognized to be effective for a particular condition, diagnosis, or body area;

(g) Any Inpatient Hospital procedure or service which has not been approved by the NYS Health Department;

(h) External prosthetics;

(i) Durable medical equipment;

(j) Care or services in connection with the detection and correction by manual or mechanical means of structural imbalance, removing nerve interference and distortion or subluxation in the human body for the purpose of the effects thereof, where such interference is the result of or related to distortion or misalignment or subluxation of the vertebral column;

(k) Hearing aids;

(l) Care or services in connection with routine care of the feet, including services in connection with corns, callauses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;

(m) Cosmetic, plastic or reconstructive surgery, except:

(i) when following surgery for treatment of trauma, infection, or other disease, or

(ii) for treatment of a congentical disease or anomaly which results in a functional defect in an Eligible Dependent child.

(n) Transsexual operations;

(o) Non-emergency transportation, such as that between facilities or to the Member's home;

(p) Drugs, medicines and disposable supplies as not administered at a Hospital or office of a Participating Physician, or not customarily provided by and administered as part of a Home Health Service;

(q) Services within, and customarily provided as, the practice of dentistry, including temporomandibular joint dysfunction. However, Vytra Services will be provided under this Agreement in connection with accidental injury to sound natural teeth within twelve months of the accident;

(r) Hearing test for members over age 17 to determine need for hearing correction;

(s) Eye tests for members over age 17 to determine need for vision correction;

(t) Autologous blood donation;

(u) Personal or comfort items;

(v) Any other limitation or exclusion stated in this Agreement.